

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in burial-transit permit, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03395										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03389									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First MARY G. Last AHLFELDT										Month March Day 31, 1969 Year										2204									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			9/14/1883			85			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			USA						Baltimore																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Catonsville			Ridgeway Manor N.H.			Housewife																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																	
Maryland			Baltimore			Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9507 Buckhorn Rd. #34																	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
John Stuart			? Schuster																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address																							
no			217165879D			Mrs. Helen Harding			9507 Buckhorn Rd.																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Carcinomatous</u>										1 yr.																			
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b)																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>68</u> , to <u>31 Mar</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>31 Mar</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>William Goodman M</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>1 Apr 69</u>														
22d. PHYSICIAN'S NAME (Type) Dr. William Goodman I										22e. ADDRESS 1334 Sulphur Spring Rd. Balto. Md																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					4/3/69					Gdns of Faith Cem,					Baltimore Co., Md.														
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Leonard J. Ruck Inc. Balto. Md. 21214										DATE APR 2 1969					<u>William Goodman</u>														

IN SENATE,
 FEBRUARY 1, 1900.
 REPORT
 OF THE
 COMMISSIONER OF THE
 GENERAL LAND OFFICE,
 FOR THE YEAR
 1899.

ALBINO B. BROWN,
 COMMISSIONER.

EDWARD J. DAVIS,
 CLERK.

THE STATE OF TEXAS,
 COMMISSIONER OF THE
 GENERAL LAND OFFICE.

REPORT OF THE
 COMMISSIONER OF THE
 GENERAL LAND OFFICE,
 FOR THE YEAR
 1899.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03396					03390					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last <i>Florence G ALBAN</i>					Month <i>3</i> Day <i>1</i> Year <i>69</i>			<i>11 A.M.</i>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
<i>F.</i>		<i>W</i>		<i>May 2, 1880</i>		<i>80</i> YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
<i>Maryland</i>		<i>USA</i>				<i>Baltimore</i> Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
<i>Randallstown</i>			<i>Chapel Hill Nursing Home</i>			<i>Housewife</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
<i>Md.</i>			<i>Balto.</i>		<i>Upperco</i>					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
<i>Harry</i>			<i>Harris</i>			<i>Alice Meyers</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
<i>No</i>			<i>213-18-8060</i>		<i>Mrs. Helen Hooper Baltimore, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Irreversible Acute Pulmonary Edema - 3 hrs</i>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <i>A.S.C.V.</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i>Generalized Arteriosclerosis</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M.: Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>12-2-</i> , 19 <i>68</i> , to <i>3-1-</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3-1-</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Cesar Valle Cervero</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-1-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>CESAR VALLE CAVERO</i>					22e. ADDRESS <i>8629 Liberty Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<i>Burial</i>		<i>March 4, 1969</i>		<i>St. Paul Cemetery</i>		<i>Upperco, Md.</i>				
24. FUNERAL DIRECTOR ADDRESS <i>J. F. Eline & Sons Reisterstown, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>MAR 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

The following is a list of the names of the persons who have been appointed to the various positions in the Department of the Interior, under the authority of the Secretary of the Interior, for the year ending June 30, 1900.

NAME	POSITION	DATE OF APPOINTMENT
John H. Smith	Assistant Secretary	January 1, 1900
William H. Jones	Chief Clerk	February 1, 1900
Charles E. Johnson	Assistant Chief Clerk	March 1, 1900
Robert L. Brown	Assistant Secretary	April 1, 1900
Thomas A. White	Chief Clerk	May 1, 1900
James M. Green	Assistant Chief Clerk	June 1, 1900
George W. Black	Assistant Secretary	July 1, 1900
Franklin D. Gray	Chief Clerk	August 1, 1900
Harold R. Hall	Assistant Chief Clerk	September 1, 1900
Arthur C. King	Assistant Secretary	October 1, 1900
William B. Lee	Chief Clerk	November 1, 1900
Charles F. Miller	Assistant Chief Clerk	December 1, 1900
Robert H. Moore	Assistant Secretary	January 1, 1901
Thomas J. Taylor	Chief Clerk	February 1, 1901
James K. Walker	Assistant Chief Clerk	March 1, 1901
George L. Young	Assistant Secretary	April 1, 1901
Franklin P. Adams	Chief Clerk	May 1, 1901
Harold Q. Baker	Assistant Chief Clerk	June 1, 1901
Arthur S. Carter	Assistant Secretary	July 1, 1901
William T. Evans	Chief Clerk	August 1, 1901
Charles U. Foster	Assistant Chief Clerk	September 1, 1901
Robert V. Gibson	Assistant Secretary	October 1, 1901
Thomas W. Harris	Chief Clerk	November 1, 1901
James X. Ingram	Assistant Chief Clerk	December 1, 1901
George Y. Jackson	Assistant Secretary	January 1, 1902
Franklin Z. Kane	Chief Clerk	February 1, 1902
Harold A. Lamb	Assistant Chief Clerk	March 1, 1902
Arthur B. Little	Assistant Secretary	April 1, 1902
William C. Munn	Chief Clerk	May 1, 1902
Charles D. Nichols	Assistant Chief Clerk	June 1, 1902
Robert E. Owen	Assistant Secretary	July 1, 1902
Thomas F. Parker	Chief Clerk	August 1, 1902
James G. Quinn	Assistant Chief Clerk	September 1, 1902
George H. Reed	Assistant Secretary	October 1, 1902
Franklin I. Russell	Chief Clerk	November 1, 1902
Harold J. Smith	Assistant Chief Clerk	December 1, 1902
Arthur K. Taylor	Assistant Secretary	January 1, 1903
William L. Vance	Chief Clerk	February 1, 1903
Charles M. Warren	Assistant Chief Clerk	March 1, 1903
Robert N. Wright	Assistant Secretary	April 1, 1903
Thomas O. Young	Chief Clerk	May 1, 1903
James P. Zane	Assistant Chief Clerk	June 1, 1903

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03397

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03391

1. DECEASED-NAME (Type or print) Richard Franklin Alban			2a. DATE OF DEATH 03 Month 27 Day 69 Year			2b. HOUR 10:05 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 01-29-97		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter		12b. KIND OF BUSINESS OR INDUSTRY n/a			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 14 Brookberry Dr. Apt 1C	
14. FATHER'S NAME First Middle Last William Alban			15. MOTHER'S MAIDEN NAME First Middle Last Sara unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16b. SOCIAL SECURITY NO. 217-01-1460		17. INFORMANT Address Mrs. Hattie R. Alban Reisterstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumogenic CA, Right with 1621 DUE TO, OR AS A CONSEQUENCE OF antitoxin Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-22-69 , to 3-27-69 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on 3-27-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE Gregory Marjoni, MD				22c. DATE SIGNED 3-27-69		22d. PHYSICIAN'S NAME (Type) Gregory Marjoni, MD			
22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 31, 69		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead, Md.			
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE Francis Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03398

03392

1. DECEASED-NAME (Type or print) Howard		First H.		Middle A.		Last Allers		2a. DATE OF DEATH March Month 20 Day 1969				2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH Dec. 15, 1899				6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore							
10. CITY OR TOWN OF DEATH Lansdowne, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2112 Alleta Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic				12b. KIND OF BUSINESS OR INDUSTRY B & A RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2112 Alleta Avenue					
14. FATHER'S NAME William A. Allers				First Middle Last				15. MOTHER'S MAIDEN NAME Mary Jane Conley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth Allers Address 21227 2112 Alleta Ave. Lansdowne							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4124 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF (c) —												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6/29 , 19 68 , to 3/20 , 19 69 , that (I) (we) last saw the deceased alive on 3/18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Herbert J. Levickas						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/20/69			
22d. PHYSICIAN'S NAME (Type) Herbert J. Levickas						22e. ADDRESS 5404 East Drive 21227							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-24-69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery				23d. LOCATION (City or Town) (County) (State) Dorsey Rd. Howard Md.					
24. FUNERAL DIRECTOR Howard H. Hubbard						ADDRESS 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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2300 , 9070 1000-0. 0 11-0 30 - 1-1 28.1

03393

03399

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY			First D. Middle ANGELOS Last			2a. DATE OF DEATH 3 Month 13 Day 69 Year			2b. HOUR 2:20 MIN		
3. SEX Female			4. RACE Cau.			5. DATE OF BIRTH 1898			6. AGE (In years last birthday) 71 YRS.		
7a. BIRTHPLACE (State or foreign country) Greece			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Baltimore, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Horsewife			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 828 S. Ponca Street			14. FATHER'S NAME First Michael Middle Diaco Last Johnnis			15. MOTHER'S MAIDEN NAME First Kula Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. None			17. INFORMANT Dr. Peter G. Angelos			Address 1505 26th St. N.W., Washington D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Acute laryngo-tracheo bronchitis and early											
DUE TO, OR AS A CONSEQUENCE OF bronchopneumonia											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive heart failure with arteriosclerotic and hypertensive cardiovascular disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/9/ , 19 69 , to 3/13/ , 19 69 , that (I) (we) last saw the deceased alive on 3/13/ , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rudiger Breiteneker			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/13/69		
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.			22e. ADDRESS Greater Baltimore Medical Center								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-15-69			23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Nicholas T. Matthews			ADDRESS 3021 Eastern Ave., Baltimore, Md.			25a. REC'D BY REGISTRAR MAR 18 1969			25b. REGISTRAR'S SIGNATURE William B. Young		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1950

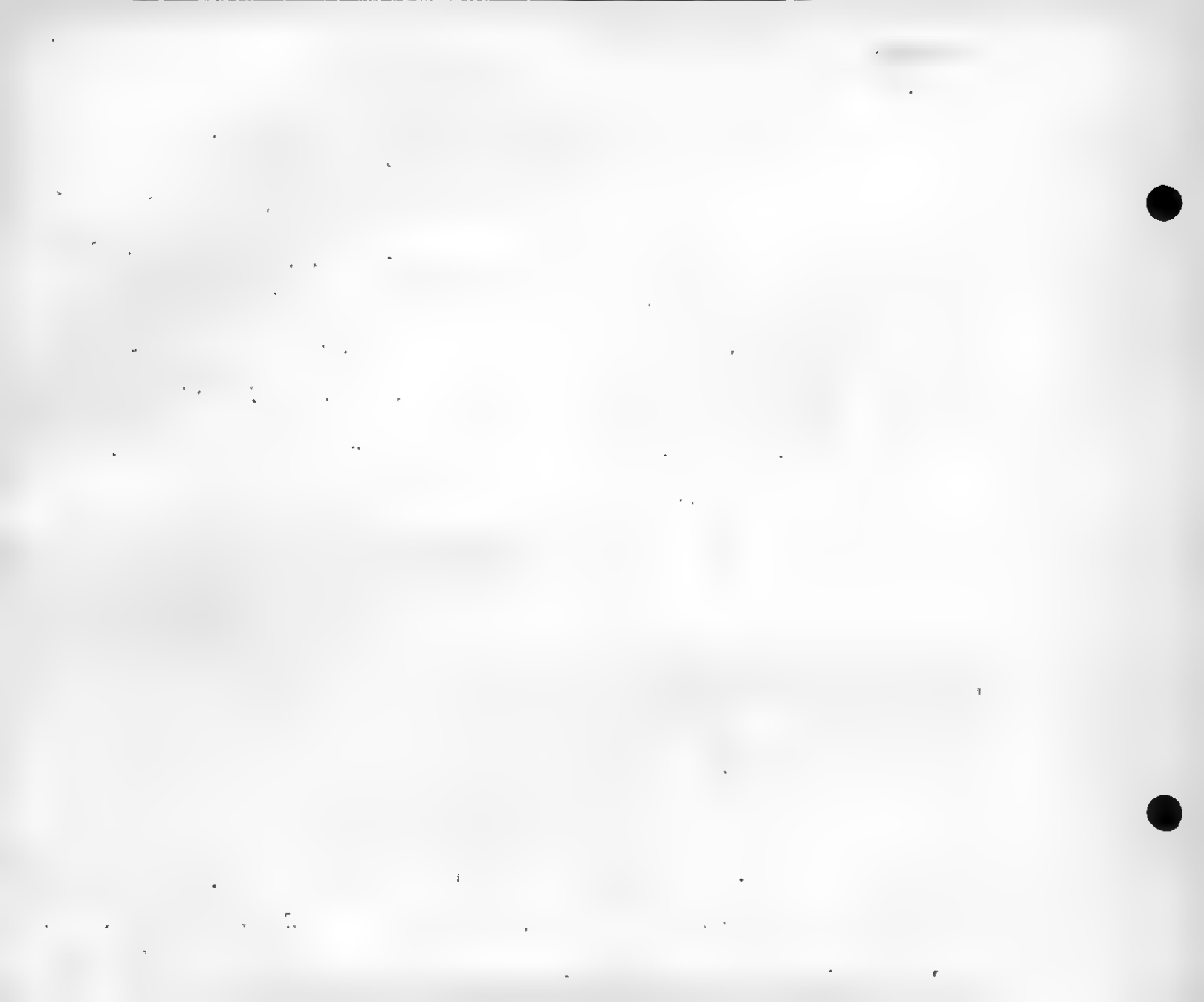
1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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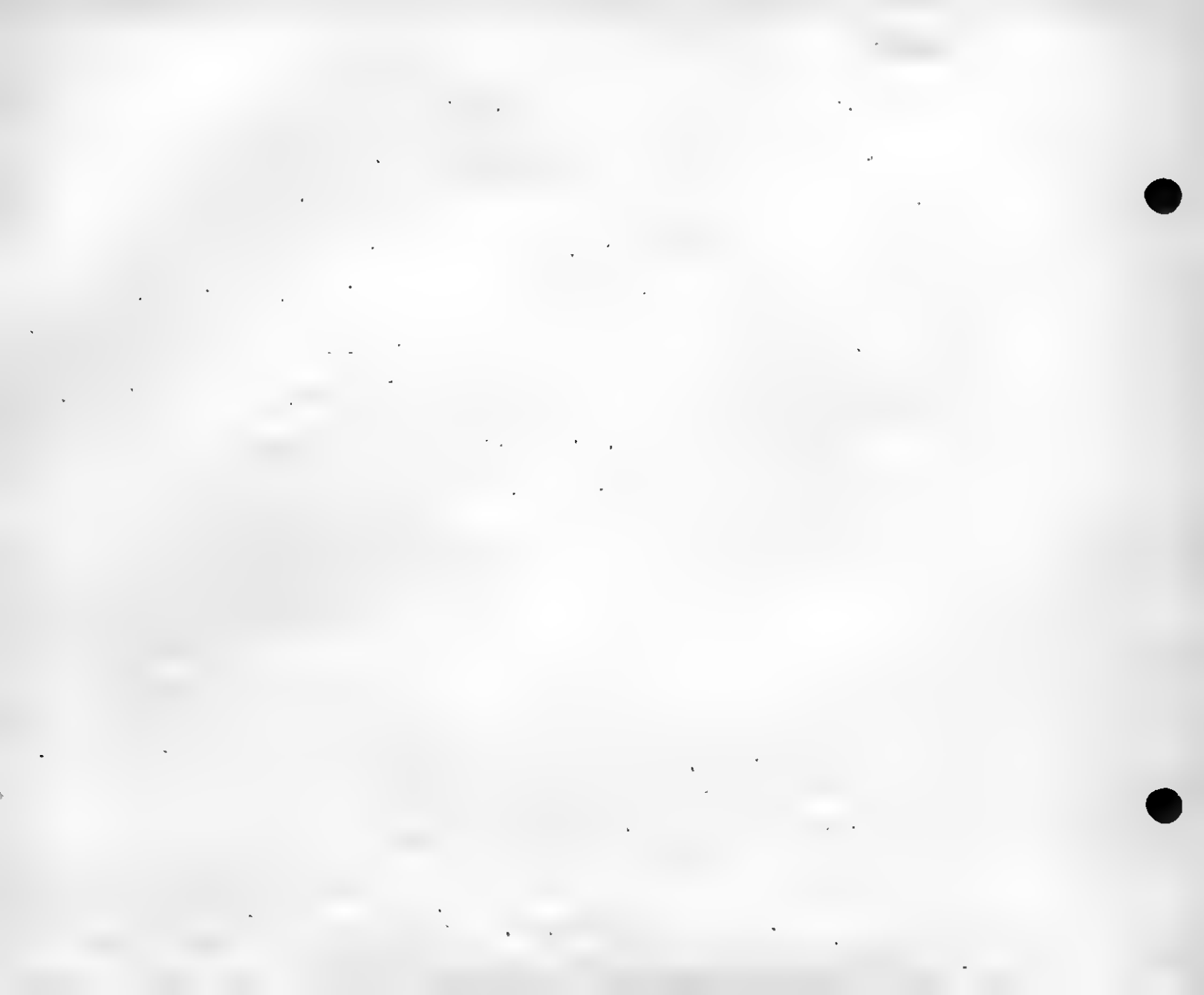
MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03400				CERTIFICATE OF DEATH				03394					
1. DECEASED NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR A	
John Fletcher Apsey Jr.								3 Month 28 Day 69 Year				12:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		7/1/1900				68 YRS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Va.		USA						Baltimore Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Towson				Greater Balto. Med. Center				Retired P.R. Man				Power Tools	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Balto.						7003 Charlesridge Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
First Middle Last John F. Apsey				First Middle Last Eunice Martien									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
Yes				216 09 3931		Elizabeth B. Apsey 7003 Charlesridge Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Rupture of thoracic aortic aneurysm												30 minutes	
DUE TO, OR AS A CONSEQUENCE OF													
(b) Hypertension												1 year	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)				21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Mar. 27, 1969, to Mar. 28, 1969, that (I) (we) last saw the deceased alive on Mar. 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Rudiger Breiteneker, M.D.										3/28/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
						6701 N. Charles St. Balto. Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)	
Cremation		3/31/1969		Greenmount Crematory				Baltimore		Balto.		Md.	
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Mitchell Wiedefeld Home 6500 York Rd.						DATE APR 7 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 7) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03401					03395						
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
Ann Lee Artinger					3 Month 7 Day 69 Year			3:07 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Female		Caucasian		5-19-19			49 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		
Virginia		U.S.A.					Baltimore		Towson		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Greater Balto. Med. Center				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Balto.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 Knoll Ridge Ct.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		
Robert Lee			Alice Jetti			No			Eugene Artinger 4 Knoll Ridge Ct.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Ruptured berry aneurysm of Circle of Willis											
4309 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
M with massive subarachnoid hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/7, 1969, to 3/7, 1969, that (I) (we) lost saw the deceased alive on 3/7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Brown, M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/8/69		
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.						22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-10-69			Meadow Ridge Mem. Park			Dorsey, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Wm. J. Trichner & Sons, Balt., Md.						MAR 11 1969			f. [Signature]		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

03402

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03396

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last ISABELLA H ATKINSON			2a. DATE OF DEATH Month Day Year 3 26 1969		2b. HOUR 10 ⁴⁵ P. M.
3 SEX F	4. RACE White		5. DATE OF BIRTH 8-13-87		6. AGE (In years lost birthday) 81 YRS.
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. NATURALIZED		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. NATURALIZED		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH ROTONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING-GRAVE STATE HOSPITAL		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN LANGLEY PARK	
14. FATHER'S NAME First Middle Last MATHEW HARWOOD		15. MOTHER'S M A DEN NAME First Middle Last ANNA PEDDER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 529-28-73388		17. INFORMANT MR. SAMUEL ATKINSON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4109 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-11 , 1969, to 3-26 , 1969, that (I) (we) last saw the deceased alive on 3-26 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death					
22b. SIGNATURE Evelio A. Felipe MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/26/69	
22d. PHYSICIAN'S NAME (Type) EVELIO A. FELIPE MD		22e. ADDRESS SPRING GROVE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/31/68		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/31/68		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem	
23d. LOCATION (City or Town) (County) (State) Washington DC		24. FUNERAL DIRECTOR W. W. Chambers		25a. REC'D BY REGISTRAR APR 1 1969	
23d. LOCATION (City or Town) (County) (State) Washington DC		24. FUNERAL DIRECTOR W. W. Chambers		25b. REGISTRAR'S SIGNATURE W. W. Chambers	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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03403

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03397

1. DECEASED NAME (Type or print) <i>N. Lucille</i>		First Middle Last <i>Bailey</i>		2a. DATE OF DEATH Month Day Year <i>March 15 1969</i>		2b. HOUR <i>10 P</i> MIN <i>20</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Nov. 23, 1888</i>		6. AGE (In years last birthday) <i>80</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CIT ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto.</i>	
10. CITY OR TOWN OF DEATH <i>Cockeysville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bonnie Blink</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Bank Teller</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>BANK</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i> COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Denton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>William F. Bailey</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Dodd</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>216-074154</i>		17. INFORMANT <i>Lillian T. Merrick</i>		Address <i>Queen Anne's Co. Sudlersville Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>							<i>1 day</i>
2509 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes</i>							<i>10 yrs</i>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Carl F. Benson, MD</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>Carl F. Benson MD</i>				22e. ADDRESS <i>3111 York Rd Balto. Md 21212</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-18-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Charlestown</i>		23d. LOCATION (City or Town) (County) (State) <i>Charlestown Ind</i>	
24. FUNERAL DIRECTOR <i>Wm. Carl Benson</i>				ADDRESS <i>105 York Rd Towson Md</i>		25a. RECD BY REGISTRAR <i>18 MAR 1969</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 113
30M REV 1-64

03404										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03398														
Item 23b, Film 410 3/21/69 km										CERTIFICATE OF DEATH																								
1. DECEASED-NAME (Type or print)					Leonard					Last Bates					2a. DATE OF DEATH Month Day Year 3 8 69					2b. HOUR M														
3 SEX male					4. RACE Negro					5. DATE OF BIRTH July 4, 1890					6. AGE (In years lost birthday) 78 YRS					F UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN										
7a. BIRTHPLACE (State or foreign country) Va.					7b. CITIZEN OF WHAT COUNTRY? U. S.					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Baltimore Md.																			
10. CITY OR TOWN OF DEATH Catonsville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Caster					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.					13b. COUNTY BALTO.					13c. CITY OR TOWN Balto.					13d. INSIDE CITY, UNITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 44 South Stockton St.														
14. FATHER'S NAME Leonard					First Middle Last Bates					15. MOTHER'S MAIDEN NAME Patsy Pratt					First Middle Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16b. SOCIAL SECURITY NO. 216-10-9910A					17. INFORMANT Records: SPRING GROVE STATE HOSPITAL										Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic renal infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>mitral leaflet prolapse</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days 170 days 60 days																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>arteriosclerotic cardiomyopathy - myocardial infarction</u>																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 3</u> , 19 <u>68</u> , to <u>March 8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE <u>W. J. Kelson M.D.</u>					DEGREE M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3/8/69																			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 3-17-69					23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial					23d. LOCATION (City or Town) (County) (State) Balto. Md.																			
24. FUNERAL DIRECTOR Wm Bailey-Kelson F. H.															ADDRESS 1348 Calhoun St.					25a. REC'D BY REGISTRAR MAR 10 1969					25b. REGISTRAR'S SIGNATURE Charles J. J...									

03405

CERTIFICATE OF DEATH

03399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

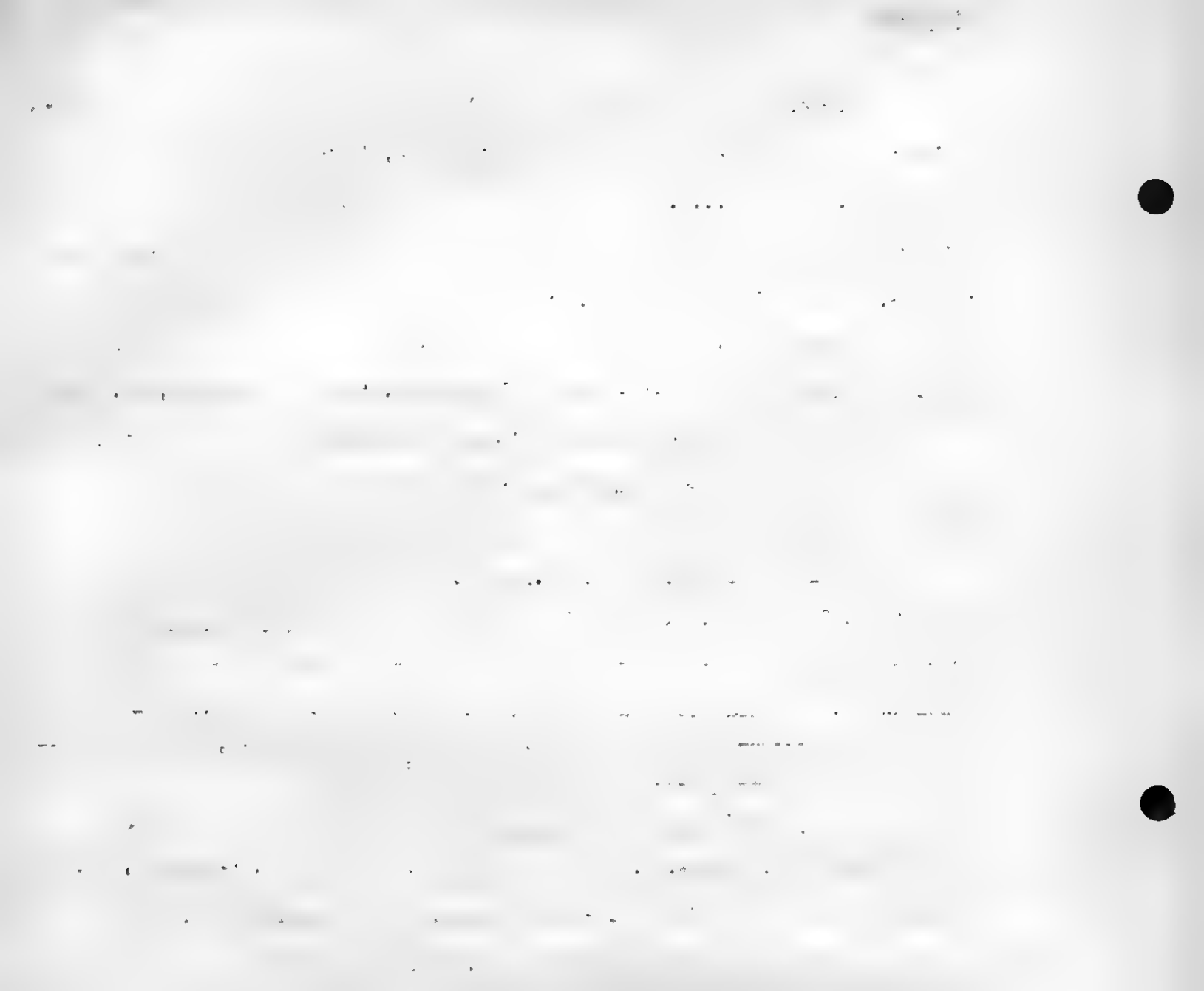
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) Sarah C. Bauer			2a. DATE OF DEATH Month 3 Day 18 Year 69			2b. HOUR 4 p. M.	
3 SEX Female		4. RACE White		5. DATE OF BIRTH 11-2-73		6. AGE (In years last birthday) 95 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore, Md.	
10 CITY OR TOWN OF DEATH Coarison md.		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Maxleigh Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		2b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6302 Eastern Parkway							
14. FATHER'S NAME First Oliver Middle Cannoles Last Shelley			15. MOTHER'S MAIDEN NAME First Mary Middle Shelley Last Shelley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 215-01-9569		17 INFORMANT Mr. Charles B. Bauer, Sr.		Address (Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-5 , 19 68 , to 3-18 , 19 69 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David J. Miller M.D.				22c. DATE SIGNED 3-18-69		22d. PHYSICIAN'S NAME (Type) David J. Miller M.D.	
22e. ADDRESS 9115 Preston Rd.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/21/69.		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.				25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03406		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03400				
Item #11, Film 3410 3/24/69 km		CERTIFICATE OF DEATH						
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR M		
Orion		Russell	Belt	March	15	69	8a.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	White	October 30, 1895		73				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U.S.A.			Baltimore				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Arcadia		Main Street-Home		Carpenter		Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		Baltimore		Arcadia		Main Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Harry		E.	Belt	Virginia	Seipp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes		WW#1 1918		Gertrude E. Belt		Upperco, Md. 21155		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease								3 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-nephro-sclerosis								?
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
<input checked="" type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. - Month - Day - Year P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home								
22a. I certify that (I) (this hospital) attended the deceased from June 10, 1966, to March 15, 1969, that (I) (we) last saw the deceased alive on 3/14/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE			DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Joseph E. Bush M. D.							3/15/69	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS					
Joseph E. Bush M. D.			117 S. Main Street, Hampstead, Md. 21074					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 18, 1969		St. Paul's Cemetery		Upperco, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tipton - Eline Funeral Home		Hampstead, Md.		MAR 20 1969		[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 14
30M REV 1-69

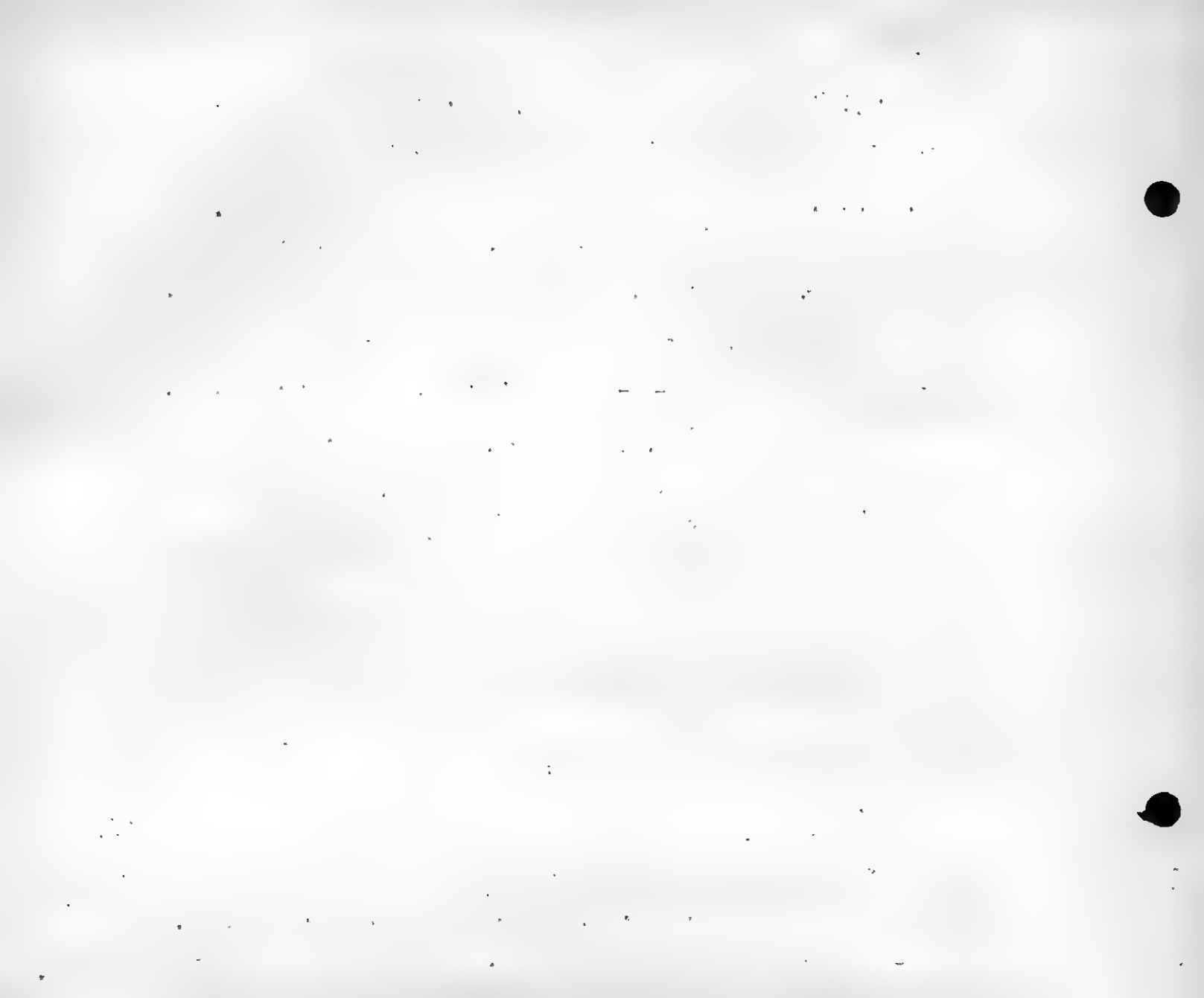
03407

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03401

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARIE KING BENSON			2a. DATE OF DEATH Month 3 Day 19 Year 69		2b. HOUR 9:30a
3. SEX FEM	4. RACE CAUC	5. DATE OF BIRTH 1/22/98		6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Balto. Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md.	
10. CITY OR TOWN OF DEATH Upperco	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Trenton Rd.		12a. USUAL OCCUPATION (Kind of work done during most of life if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Upperco	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Trenton Rd.	
14. FATHER'S NAME First Middle Last Charles E. King		15. MOTHER'S MAIDEN NAME First Middle Last Martha Ella Nolte			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-14-7194		17. INFORMANT Address Wilbur M. Benson Upperco, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Intestinal Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/17 , 19 69 , to 3/19 , 19 69 , that (I) (we) last saw the deceased alive on 3/19 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stuart Oppenheimer		DEGREE MD.		22c. DATE SIGNED 3/19/69	
22d. PHYSICIAN'S NAME (Type) STUART OPPENHEIMER		22e. ADDRESS 3309 RETLAW ROAD, BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 22, 1969		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	
23d. LOCATION (City or Town) (County) (State) Upperco, Md.					
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home		ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR MAR 24 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2c. DATE OF DEATH Month Day Year		
EDWARD			VERNON		BESSLING		MARCH 30, 1969		4:50A M		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS	
MALE		WHITE		9/21/19		49 YRS.		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE				Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		VETERANS ADMIN. HOSPITAL		TRUCK DRIVER		working Co.					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MARYLAND				BALTIMORE				614 SCOTT STREET			
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last		
ALBERT			-		BESSLING		-		MARY - - BUCK		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT		Address				
YES			WWII		218 07 8268		CLINICAL RECORDS, VAH, FT. HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF THE LUNGS</u>										MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b PLACE OF INJURY (At home, farm, street, factory) (Office, building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MAR. 21</u> , 19 <u>69</u> , to <u>MAR. 30</u> , 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>MAR. 30</u> , 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (view) the body after death											
22b SIGNATURE <u>Gracito V. Patricio</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/30/69			
22d. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO, M.D.						22e ADDRESS VAH, FT. HOWARD, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 4/2/69			23c NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY			23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.		
24 FUNERAL DIRECTOR <u>Cowan Funeral Home</u>			ADDRESS POPPLETON & HOLLINS ST., BALTO., MD. 21223			25a REC'D BY REGISTRAR APR 1 1969			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

• 1 2 3 4 5 6 7 8 9 10 11 12

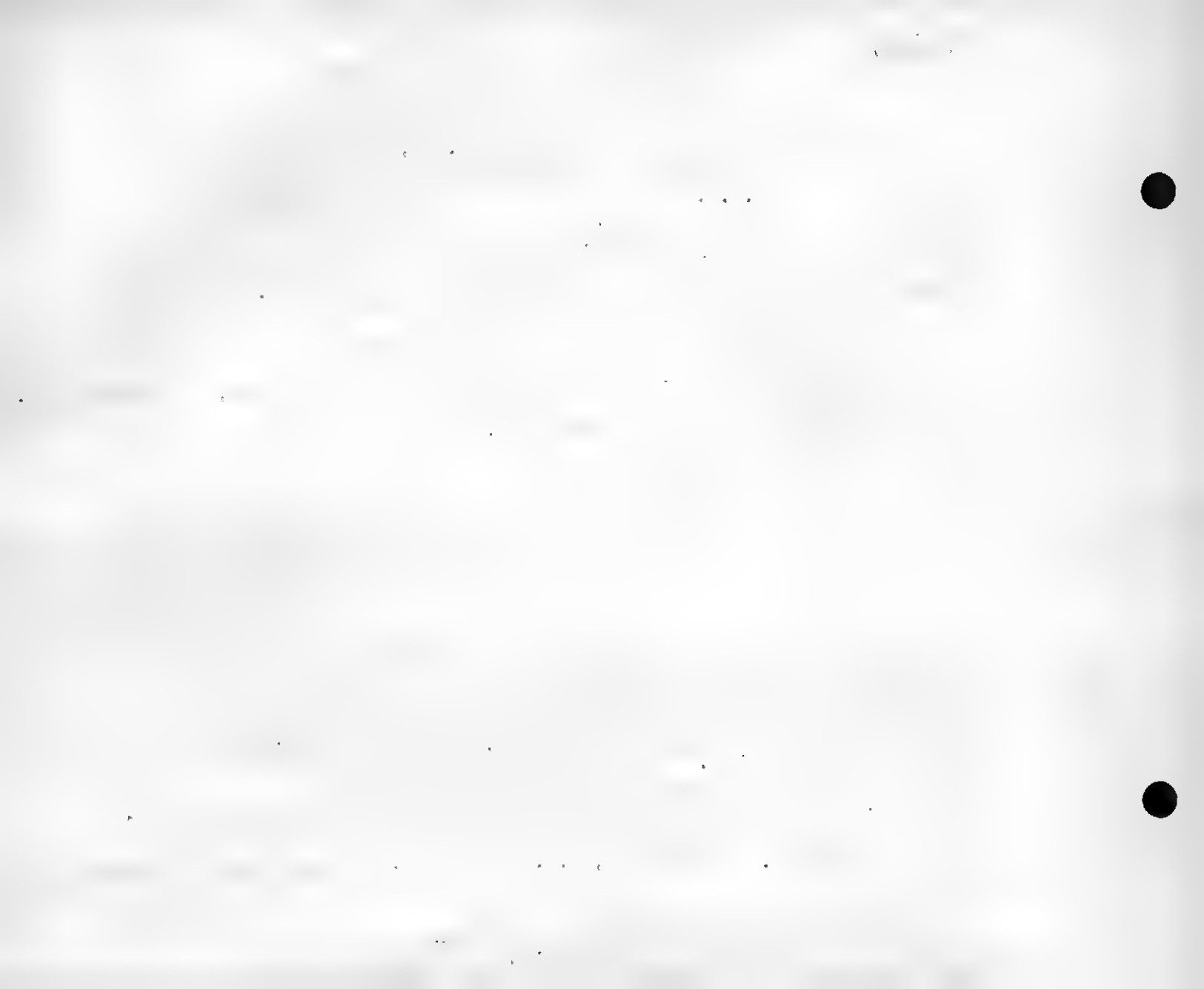
• 1 2 3 4 5 6 7 8 9 10 11 12

• 1 2 3 4 5 6 7 8 9 10 11 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03409 CERTIFICATE OF DEATH 03403									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
LEROY STANLEY BOLL						March Month 17 1969		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years first birthday)		7 UNDECEASED 1 YEAR MONTHS 1 UNDECEASED 24 HRS. HOURS MIN	
Male		White		Nov. 20, 1901		67 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMINISTRATION HOSPITAL		PAINTER		John Campbell			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND				BALTIMORE				417 E. 31st Street	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
EMORY FRANKLIN BOLL			ATTA CROMER						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
YES WW-11			217 05 75 12		Clinical Recds, VA Hospital, Fort Howard, Md.				
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION									Recent
4109 DUE TO, OR AS A CONSEQUENCE OF PULMONARY EDEMA									Recent
Cond't ans, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC HEART DISEASE									Old
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (X) (this hospital) attended the deceased from Mar. 4, 19 69, to Mar 17, 19 69, that (X) (we) last saw the deceased alive on Mar. 17, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE madhav D. Barhanpurkar DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 3/18/69		
22d PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.					22e ADDRESS VA Hospital, Fort Howard, Maryland				
23a BURIAL, CREMATION (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		3/21/69		Baltimore National		Baltimore, Maryland			
24 FUNERAL DIRECTOR SCHIMNEK FUNERAL HOME					25a REC'D BY REGISTRAR BALTO, MD. MAR 24 1969		25b REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03410					03404					
1 DECEASED NAME (Type or print) First Middle Last					2a. DATE OF DEATH			2b. HOUR		
MARY E BOPP					3 Month 23 Day 69 Year			1 10 P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 FINGER 1 YEAR		
Female		Caucasian		May 11, 1886		62 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				BALTIMORE Co.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON			Great. Balt. MED. Cen.			Registered Nurse		Retired		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1619 Cottage Lane #4	
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last					
Gregory Bopp					Katharine Crist					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT Address					
No			215-32-9982		Mrs. Albert Day 1619 Cottage Lane #4					
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u>										
174X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis to Lumbar Spine</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Long Bones</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <u>Feb. 22, 1969</u> to <u>March 23, 1969</u> , that (I) (we) lost saw the deceased alive on <u>March 23, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>G. Naeim</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/23/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. Faramarz Naeim, M.D.</u>						22e ADDRESS <u>6701 N. Charles St. 21204</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial			3/26/69		Holy Cross Cemetery		Baltimore Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck Inc. 5305 Harford Road 21214						DATE <u>MAR 24 1969</u>		<u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: SPANN FUNERAL HOME, CHESTER, SOUTH CAROLINA.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03411											
03405											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
JOHN QUINCY BOYD						MARCH 4 1969			11:35 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		F UNDER 1 YEAR MONTHS DAYS		H UNDER 24 HRS. HOURS MIN	
Male		COLORED		2/19/23		46 YRS					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
South Carolina			U.S.A.						Baltimore, Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Fort Howard			Veterans Administration Hospital			Janitor			Chemical Co.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13e STREET AND NUMBER		
Maryland			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			930 S. Paca Street		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Joseph Boyd			Bessie Archer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
Yes WW II			247 32 1578			Clin. Records, VAH, Fort Howard, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF BRAIN WITH HEMORRHAGE											
1621 DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF LUNG (REMOVED)											
DUE TO, OR AS A CONSEQUENCE OF METASTATIC CARCINOMA ILLIUM, LEFT COLON, LIVER AND PERITONEUM											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION			State		
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No			City or Town County		
22a. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1968, to March 4, 1969, that (I) (we) last saw the deceased alive on March 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Madhav D. Barhanpurkar						3/5/69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
MADHAV D. BARHANPURKAR, M.D.						VA Hospital, Fort Howard, Md.					
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2-9-69		Rehoboth cemetery			Chester, South Carolina			
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Rice Funeral Home 661 W. Barre St. Balto Md.						MAR 6 1969			J. L. L. L.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

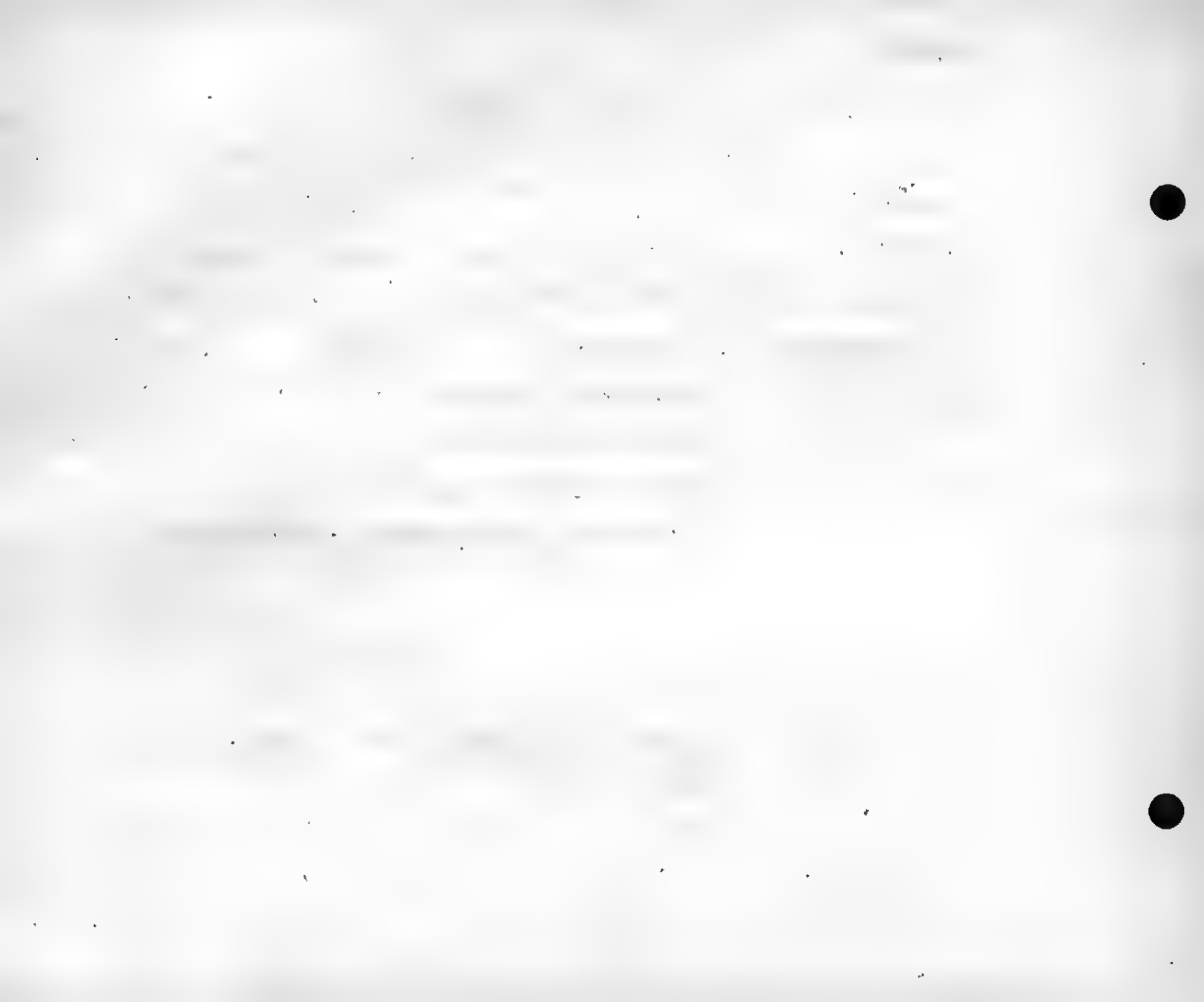
03412

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03406

1. DECEASED-NAME (Type or print) CLARENCE QUAY BRADLEY			2a. DATE OF DEATH 3 Month 17 Day 69 Year			2b. HOUR 6:55 A.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 12/14/00		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.			
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 OAK LEE VILLAGE	
14. FATHER'S NAME First Middle Last AMBROSE G. BRADLEY			15. MOTHER'S MAIDEN NAME First Middle Last HANNAH ? (Unknown) ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 177-09-2650		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 41-7 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary Tuberculosis + Pneumonia DUE TO, OR AS A CONSEQUENCE OF 15 yrs 1 mo								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 69 , to 3/17 , 19 69 , that (I) (we) last saw the deceased alive on 3/17 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. Newcomer				DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/17/69	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-20-69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City Balto. Md.			
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE MAR 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03413

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03407

1. DECEASED NAME (Type or Print) HARRY H. BREGEL SR			First Middle Last			2a. DATE KNOWN OF DEATH EST. MATED 3-24-1969			2b. HOUR JR 9:00 PM				
3 SEX M	4 RACE W	5. DATE OF BIRTH 5/2/88	6 AGE (In years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 3 Day 24 Year 1969			2d. HOUR 9:00 PM		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.			12b. KIND OF BUSINESS OR INDUSTRY STEEL				
10. CITY OR TOWN OF DEATH ESSEX			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1433 KENT RD.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD.			13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1433 KENT RD.				
14. FATHER'S NAME First Middle Last ?			15. MOTHER'S MAIDEN NAME First Middle Last ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK			16b. SOCIAL SECURITY NO 214-03-2279			17. INFORMANT HARRY H. BREGAL JR.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK			16b. SOCIAL SECURITY NO 214-03-2279			17. INFORMANT HARRY H. BREGAL JR.			ADDRESS 1453 SUSSEX			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) SENILITY DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE M.B. DAVIS				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/24/69					
EXAMINER'S NAME (Type) M.B. DAVIS 6800 MORNINGSTAR RD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 3/27/69				23c. NAME OF CEMETERY OR CREMATORY BALTO. CEM					
24. FUNERAL DIRECTOR J.G. CONNELLY SONS				ADDRESS 300 MACE				25a. REC'D BY REG STRAR MAR 26 1969					
23d. LOCATION (City or Town) (County) (State) BALTO. MD				25b. REGISTRAR'S SIGNATURE [Signature]									

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03408	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										03414	
1. DECEASED NAME (Type or Print)			First	Middle	Last		2a. DATE KNOWN OF DEATH			2b. HOUR	
Timothy J. Brennan							March 10 1969			5 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
M	W	5/3/1962		6 YRS	MONTHS DAYS HOURS MIN				March 10 1969		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U. S. A.				Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph's Hospital			None			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.			21212				1112 Cedarcroft Road	
14. FATHER'S NAME				First	Middle	Last		15. MOTHER'S MAIDEN NAME			
Charles R. Brennan								Alice VonRinteln			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
No				None		Charles R. Brennan			(Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Be Natural Cause</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Spontaneous Sudden</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19 P.M.			Family Permission					
22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
<u>Charles R. Brennan</u>			7501 York Rd			M.D.			3/11/69		
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			3/13/1969		New Cathedral			Baltimore Md.			
24. FUNERAL DIRECTOR			H.W. Jenkins & Sons Co.			4905 York Rd.			Baltimore, Md.		
25a. REC'D BY REGISTRAR			DATE			25b. REGISTRAR'S SIGNATURE					
MAR 13 1969						Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03409

03415

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Morris nmi Brenner			2a. DATE OF DEATH Month Day Year MARCH 2 1969		2b. H.O.J.R. 6 30 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 4-15-94		6 AGE (in years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) New York	7b CITIZEN OF WHAT COUNTRY? U.S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County Md		
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETAIL	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto	13c CITY OR TOWN Balto	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2204 Tucker Lane #7
14. FATHER'S NAME First Middle Last SIMON BRENNER		15 MOTHER'S MAIDEN NAME First Middle Last BESSIE ?			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or Link known) (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO		17 INFORMANT Address MRS. ROSE BRENNER, 2204 TUCKER LANE #21207	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 5001 DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE PARALYTIC ILEUS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION 3-17-69		19b CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-16, 1969, to 3-21, 1969, that (I) (we) last saw the deceased alive on 3-21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Jesus G. Santiano M.D.		22c. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL		22e. DATE SIGNED 3-21-69	
22d. PHYSICIAN'S NAME (Type) JESUS G. SANTIANO					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 3-23-69		23c NAME OF CEMETERY OR CREMATORY SHAAREI ZION	
24 FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD		23d LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND		23e REC'D BY REGISTRAR MAR 26 1969	
24b ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD		25b REGISTRAR'S SIGNATURE James Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS 100-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03410	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI DEATH MATED		2b HOJR	
JAMES Brenton		ALIAS		James		GRANT		March 30, 1969		12:40	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOJR	
Male	White	Dec. 12, 1928	40					March 30, 1969		12:40	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Pennsylvania		U.S.A.				Baltimore					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Towson		St. Joseph Hospital		Owner		Chilney Co.					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Baltimore		Baltimore				4205 Belle Grove Road			
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
John Brenton				Luma Friesleben							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give year or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
Yes		2-13-51 to		169-22-6108		Mrs. Jeanette Marie Grant		Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year ? HOUR A.M. ? P.M. ? 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver lost control and struck tree							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No City or Town County State Warren Rd. near Merrymans Mill Rd. Balto. M.D.							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/30/69	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		4-1-69		Baltimore National		Baltimore, Maryland					
24 FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy		21225		25a RECD BY REGISTRAR DATE APR 7 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03411		
03417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR
RUTH			HMLDA		BREWER		<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 3 <input type="checkbox"/> 22 <input type="checkbox"/> 189			8-25		
3 SEX	4. RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	April 3, 1919		49 YRS					Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> March 22 1969		8-25	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Wisconsin			U.S.A.				Balto.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Phoenix			Rt #1 Box 273 A Alliston Rd.						Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if inst. tut. on. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY (H.M. 15?)		13e. STREET AND NUMBER			
Md.					Phoenix		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt #1 Box 273 A Alliston Rd			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			
John			Henry		Anschutz				Hulda			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS				
No					Kenneth B. Brewer			Rt #1 Box 273 Alliston Rd				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>												
4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Fatty metamorphosis of liver												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				March 22, 1969				
Ronald N. Kornblum, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation				3-25-69		Memorial Park		Skokie, Ill.				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. E. Johnson						8521 Loch Raven Blvd. 21204		MAR 26 1969		Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03418

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03412

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>		Month Day Year		2b HOUR	
BENJAMIN		H.		BRILL						19		M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
male	white	9/22/1919		49 YRS		MONTHS DAYS		HOURS MIN		Month Day Year		12:25 A.M.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH							
Virginia		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore						Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Woodlawn		905 Southridge Road		Model maker		Restinghouse							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Maryland		Baltimore		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		905 Southridge Road					
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle	
Ethyl P.		Brill						Emma		J.		O'Donovan	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
Yes		U.S. II				Mrs. Lora Brill (Sister)		(Same)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head</u> <u>755 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOURS:MIN 9:45 PM 3/2/ 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. shot self in head					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home				21f. LOCATION Street or R.F.D. No City or Town County State Woodlawn, Baltimore, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Werner U. Spitz</u>				M.D.				22b. DATE SIGNED 3/3/69					
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				3/6/1969				Baltimore National					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
Charles E. Brown, Sr., Inc., 901 Haller St., Baltimore, Md.								25b. REGISTRAR'S SIGNATURE Charles E. Brown, Jr.					



03419

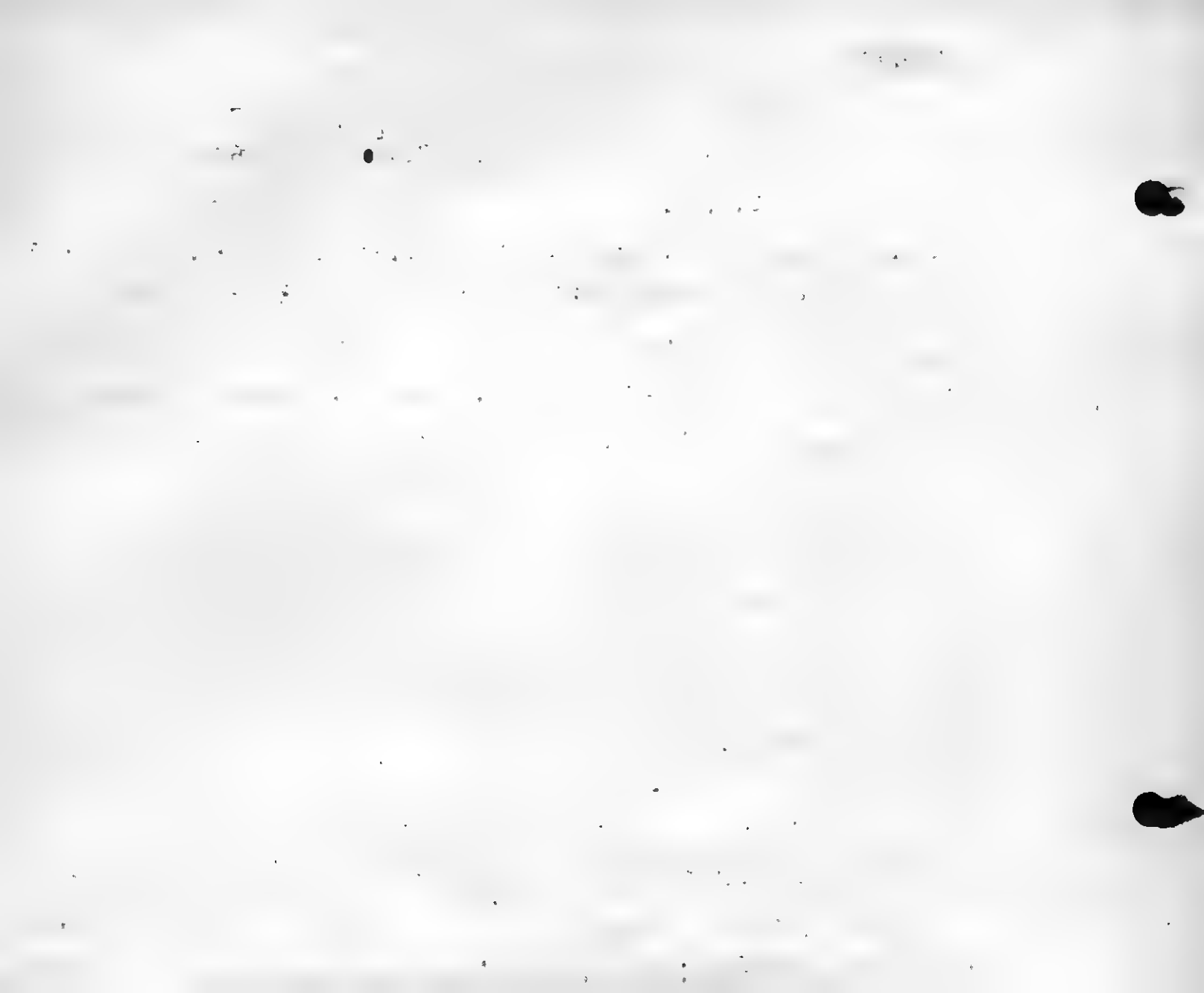
CERTIFICATE OF DEATH

03413

1. DECEASED NAME (Type or print) FRANKLIN			First H Middle BROWN Last			2a. DATE OF DEATH Month 3 Day 27 Year 69			2b. HOUR 2:15 M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH July 8, 1901			6. AGE (in years last birthday) 67		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Baltimore 21204			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Broadcast Rec.			12b. KIND OF BUSINESS OR INDUSTRY Packer-Bendix		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY - AM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 10 Orkney Court 21212			14. FATHER'S NAME First John Middle L. Last Brown			15. MOTHER'S MAIDEN NAME First Zenobia Middle Williams Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 215-01-1600			17. INFORMANT Mrs. Johanna G. Brown			Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from JAN , 19 67 , to 3/27 , 19 69 , that (I) (we) last saw the deceased alive on 3/24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert E. May			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 3/27/69		
22d. PHYSICIAN'S NAME (Type) Dr. Robert May			22e. ADDRESS 5662 THE ALAMEDA								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/31/69			23c. NAME OF CEMETERY OR CREMATORY Lake View			23d. LOCATION (City or Town) (County) (State) Liberty Road, Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR APR 1 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03420

CERTIFICATE OF DEATH

03414

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P		
LAURA				BROWN	3 24 69		7:45 M		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
female	Negro		Unknown 1889		80 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Domestic		Private Home			
13a. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - HOUSE? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Balto		Towson				130 Chesapeake Avenue	
14. FATHER'S NAME		15. MOTHER'S M A DEN NAME		16a. WAS DECEASED EVER IN U S ARMED FORCES? Yes, (a, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		17. INFORMANT Address			
Daniel		Brown		Sophia		Humphrey			
16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
none		Dorothy Brown		409 Fairmount ave Towson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure									
41. + DUE TO, OR AS A CONSEQUENCE OF Severe dehydration and									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-24-1969, to 3-24-1969, that (I) (we) lost the deceased alive on 3-24-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Lorna Gaudiel		M.D. DEGREE		6720 York Road, Baltimore, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/29/69		Pleasant Rest		Towson, Balto., Co. Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. V. Chatman, Jr.		1701 M & Culloch St. Balto. Md.		MAR 27 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
SM 110

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03421 CERTIFICATE OF DEATH 03415											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
MINNIE			B.		BROWN				MARCH Month 10, 1969		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7. UNDER 24 HRS		
FEMALE		WHITE		FEBRUARY 24, 1888			81 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland			U.S.A.					Baltimore, Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			At home					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		3a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore			Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2623 Wendover Rd. #21234	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME		
Louis T Wilson									KEZIAH BARNES		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No			218 098522B			Catherine Young			1309 Morning Ave		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Anemia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Acute myelogenous leukemia											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Generalized Arteriosclerosis											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from February 20, 1969 to March 10, 1969, that (I) (we) last saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Guadalupe Gokim DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c DATE SIGNED March 10, 1969											
22d. PHYSICIAN'S NAME (Type) Gualberto Gokim, M.D. 22e ADDRESS 7620 York Road Towson, Maryland #21204											
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			3-13-69		Moreland Mem. Park			Taylor Ave Balto Md			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Burge Funeral Home Balto Md						DATE MAR 11 1969			Charles Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03422

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03416

1. DECEASED NAME (Type or print) Odis I. Breyer			2a. DATE OF DEATH March Month 7 Day 69 Year			2b. HOUR 6:00 AM			
3. SEX F.M.		4. RACE White		5. DATE OF BIRTH May 19, 1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3605 Templar Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Wife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY, Y.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER 3605 Templar Rd. 21133	
14. FATHER'S NAME First James Middle Holt Last			15. MOTHER'S MAIDEN NAME First Alice Middle E. Last Spain						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 579-48-6648		17. INFORMANT Mrs. Carroll J. Kite		Address 3605 Templar Rd. 21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver compl. 5719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) Cirrhosis stating the underlying cause (c) lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 7 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1960 , to 3/7 , 19 69 , that (I) (we) lost saw the deceased alive on 3/6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Morton Ellin				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/7/69			
22d. PHYSICIAN'S NAME (Type) Morton Ellin				22e. ADDRESS 8629 Liberty Rd.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 10, 69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick Ave. Balto City			
24. FUNERAL DIRECTOR Loring Byers				ADDRESS 8728 Liberty Road Randallstown.		25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03423		CERTIFICATE OF DEATH						03417			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR a		
Florence			C. Buchanan			March 25, 1969			9:10 a		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Female		White		3-16-14			55 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Wayland, Mich.		U.S.					Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Balto. City Bo. Educ.			Education		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Parkville				3036 Fourth Ave. 21234		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Monroe W. Aubil			Hattie Finkbeiner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			385-09-4782		Hospital records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis											
1827 DUE TO, OR AS A CONSEQUENCE OF (b) Poorly differentiated malignant uterine tumor											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from February 22, 1969, to March 25, 1969, that (I) (we) last saw the deceased alive on March 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Benjamin DelCarmen, M.D. -DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED March 25, 1969			
22d. PHYSICIAN'S NAME (Type) Benjamin DelCarmen, M.D.						22e. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3/29/69		Hillside Cemetery		Glenside, Pa.					
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road						25a. REC'D BY REGISTRAR MAR 27 1969		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION



03424

CERTIFICATE OF DEATH

03418

1. DECEASED-NAME (Type or print) GEORGE EARL BURDETTE			2a. DATE OF DEATH Month March Day 13 Year 1969			2b. HOUR 10:25 P	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 8-12-1895		6. AGE (In years lost birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) retired -Elec.		12b. KIND OF BUSINESS OR INDUSTRY Own Business	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY U.M. TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3108 Mareco Ave.		13f. CITY OR TOWN Baltimore		13g. STATE Md		13h. ZIP CODE 21213	
4. FATHER'S NAME First George Middle Burdette Last Burdette			5. MOTHER'S MAIDEN NAME First Emma Middle Reeder Last Reeder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO 214-34-4301		17. INFORMANT 4415 Fullerton Ave., 21236 Joseph A. Frese, son-in-law		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory insufficiency 342X DUE TO, OR AS A CONSEQUENCE OF (b) Massive aspiration of gastric contents DEATH DUE TO CONSEQUENCE OF (c) With Pulmonary edema							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinson's Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from February 10, 1969 , to March 13, 1969 , that (I) (we) last saw the deceased alive on March 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cilliani				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-14-69	
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.				22e. ADDRESS 7620 York Road, Towson, Md. 21204			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/17/69		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REGD. BY REGISTRAR DATE MAR 18 1969		25b. REGISTRAR'S SIGNATURE Richard L. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

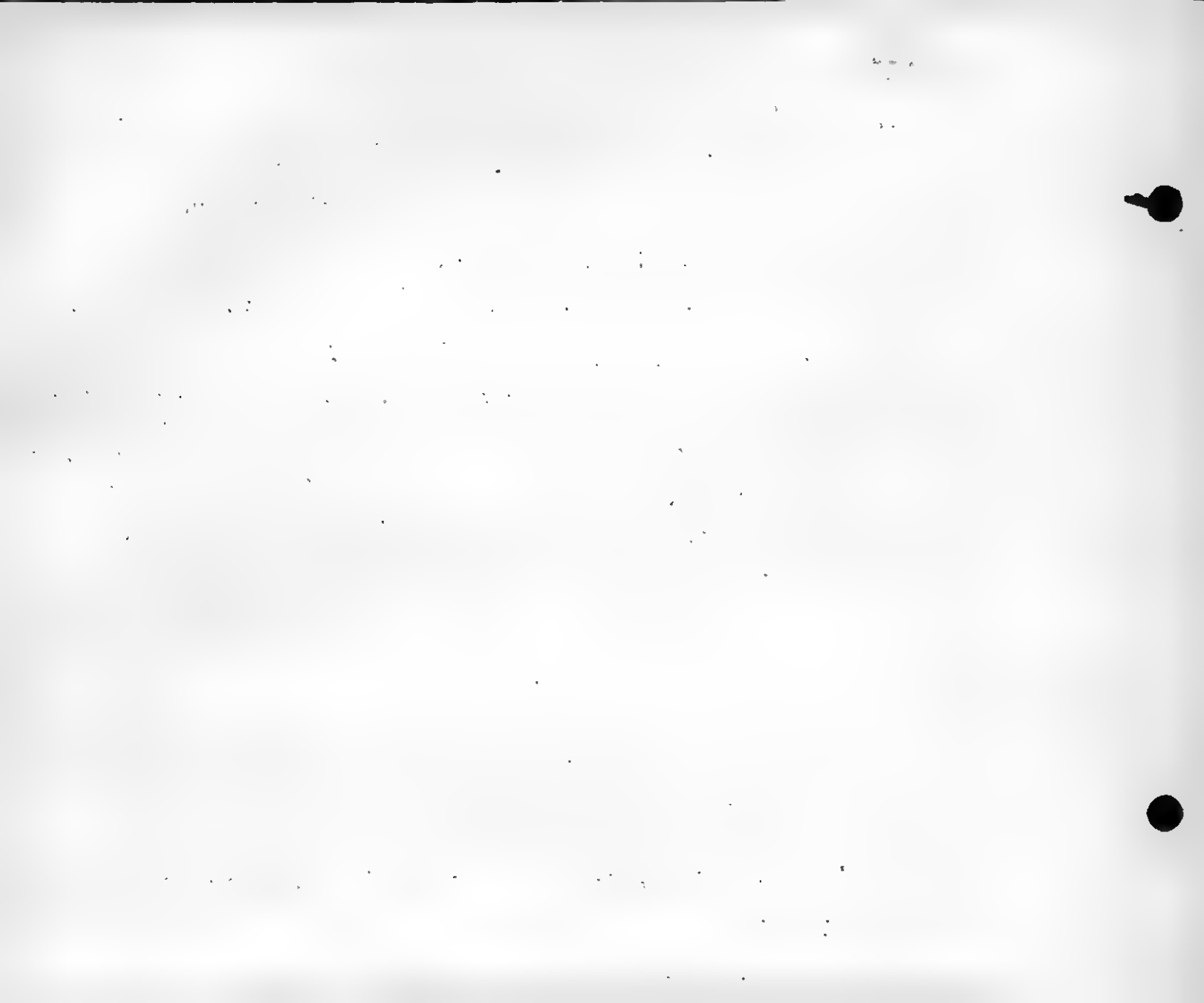
03425

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03419

1. DECEASED NAME (Type or print) WILLIAM BURDETTE			2a. DATE OF DEATH Month 3 Day 15 Year 1969			2b. HOUR 1:30 P.M.					
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 12-4-1914		6. AGE (In years last birthday) 54 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.					
10. CITY OR TOWN OF DEATH Mount Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD COUNTY Baltimore			13c. CITY OR TOWN MT. WILSON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 607 PA AVENUE BALT. MD.		
14. FATHER'S NAME First James Middle BURDETTE Last BURDETTE			15. MOTHER'S MAIDEN NAME First MARY Middle WHEELER Last BURDETTE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 136-20-5613			17. INFORMANT Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1- Acute cor pulmonale DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive airway diseases DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Acidosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 5 years 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Minimal Pulmonary Tuberculosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-7-69 , to 3-15 , 19 69 , that (I) (we) last saw the deceased alive on 3-15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Newcomer						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3.19.69			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Cowell Funeral Home						ADDRESS Pikesville, Md.			25a. REC'D BY REGISTRAR DATE APR 20 1969		
									25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03426		CERTIFICATE OF DEATH				03420			
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
ELMER JERIMIAH BURNETT						March 3 1969			5:45 M
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS	
MALE	Negro		9/5/17			51			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR WHERE DECEASED WAS IN HOSPITAL		12a USUAL OCCUPATION (Kind of work done during week before death)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		Administration Hospital		Workshop for the Blind					
13a USUAL RESIDENCE (Where deceased lived, if institution adm.) STATE			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND			BALTIMORE				4207 Springdale Avenue		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
ELMER --- BURNETT						FLORENCE			CROSS
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (justify)		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
YES WW-II		218 03 8690		Clinical Rcds VA Hospital, Fort Howard, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC GANGRENE BOTH THIGHS AND ANTERIOR ABDOMINAL WALL									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPTICEMIA									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from Dec. 30, 1968, to March 3, 1969, that (X) (we) last saw the deceased alive on Mar. 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do not) view the body after death									
22b SIGNATURE					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
MADHAV D. BURHANPURKAR							3/4/69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
MADHAV D. BURHANPURKAR, M.D.					VA Hospital, Fort Howard, Md.				
23a BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-6-69		Baltimore National		Baltimore, Maryland			
24. FUNERAL DIRECTOR		Morten & Dyett Funeral Home				RECEIVED BY REG STRAR		25b. REG. STRAR'S SIGNATURE	
		1701 Laurens St. Balto. Md.				MAR 5 1969		Charles Judge	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03427

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03421

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
WILLIAM EDWARD BURNS					March 10, 1969					9:10 P. M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
male	white	March 21, 28		40 YRS.	MONTHS		DAYS	HOURS	MIN	March 10, 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Pennsylvania		U.S.A.		Baltimore							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
Dulaney Valley		Loch Raven Dam			Police Officer			Law Enforcement			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Baltimore		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8630 XXXX Oak Road			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Patric Henry Burns				Margaret Julia Fahey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				Korea		Evelyn H. Burns 8630 Oak Road Balto. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Gunshot Wound of the Head</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
CALSE OF DEATH		HOUR A.M. UNK 3/10/ 1969		subj. shot self in head							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Parking lot						Baltimore, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		3/11/69			
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3-14-69		Moreland Memorial		Baltimore Co. Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE	
Wm. E. Johnson 8521 Loch Raven Blvd. 21204								DATE MAR 17 1969		Wm. E. Johnson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

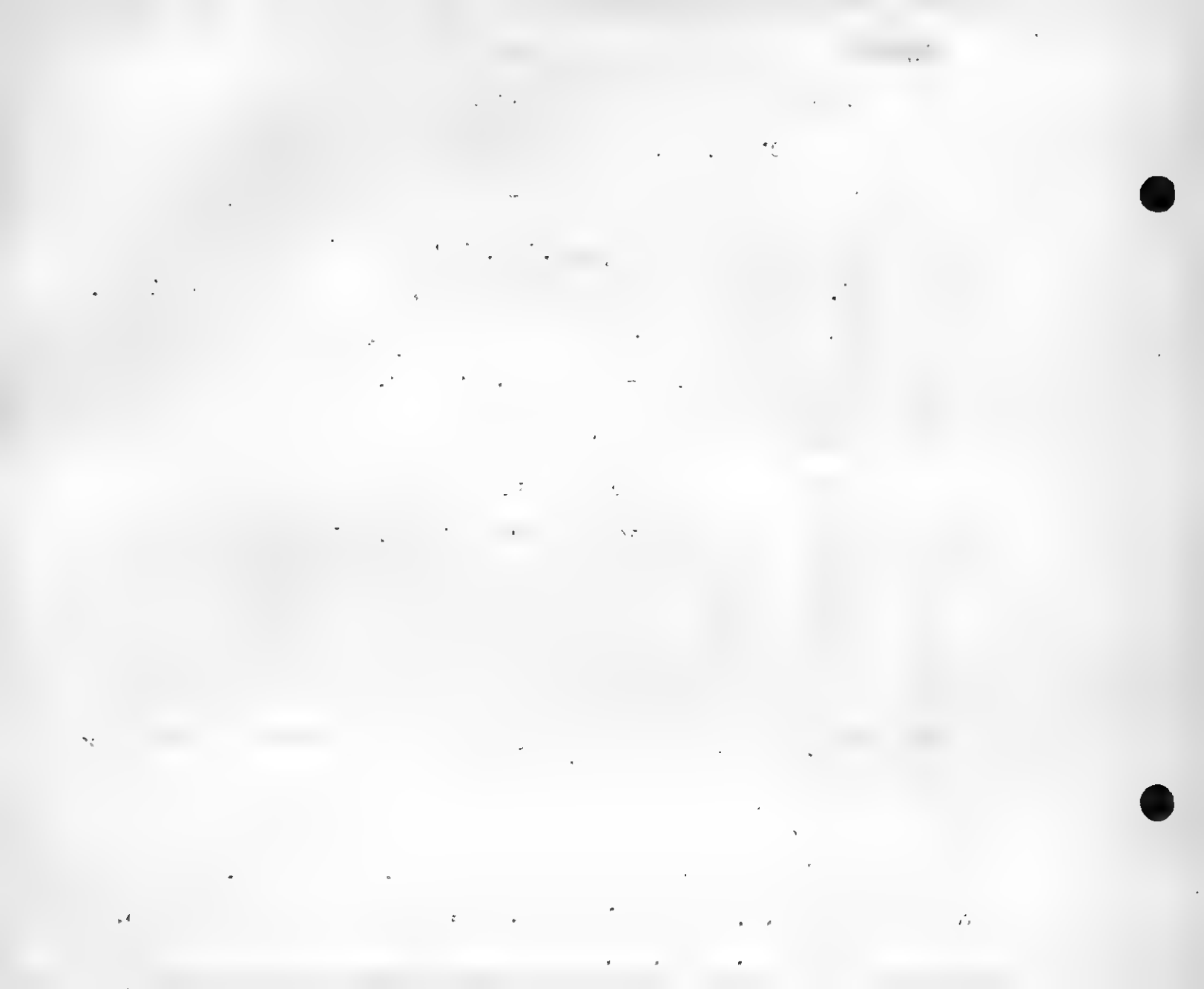
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03428

03422

1 DECEASED NAME (Type or print) KATHERINE (NMN) BYERTS			2a. DATE OF DEATH 3 Month 15 Day 69 Year			2b. HOUR 3:25 a.m.			
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH 3/9/1882		6. AGE (In years last birthday) 86 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED. CENT.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5626 Midwood Ave.	
14 FATHER'S NAME First Middle Last Roger O'Donnell			15 MOTHER'S MAIDEN NAME First Middle Last Margaret Murphy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 215-50-8471		17 INFORMANT Address Mr. Joseph J. Byerts, 3702 The Alameda #18					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 412.3 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/2 , 19 69 , to 3/15 , 19 69 , that (we) last saw the deceased alive on 3/15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Barry P. Friedlander</i>		22c. DATE SIGNED 3/15/69		22d. PHYSICIAN'S NAME (Type) BARRY FRIEDLANDER		22e. ADDRESS 6701 N. CHARLES ST.			
23a. BURIAL CREMATION, REMOVAL (Specify) Entombment		23b. DATE 3/18/69.		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Mausoleum		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 212 14				25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE <i>Francis Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

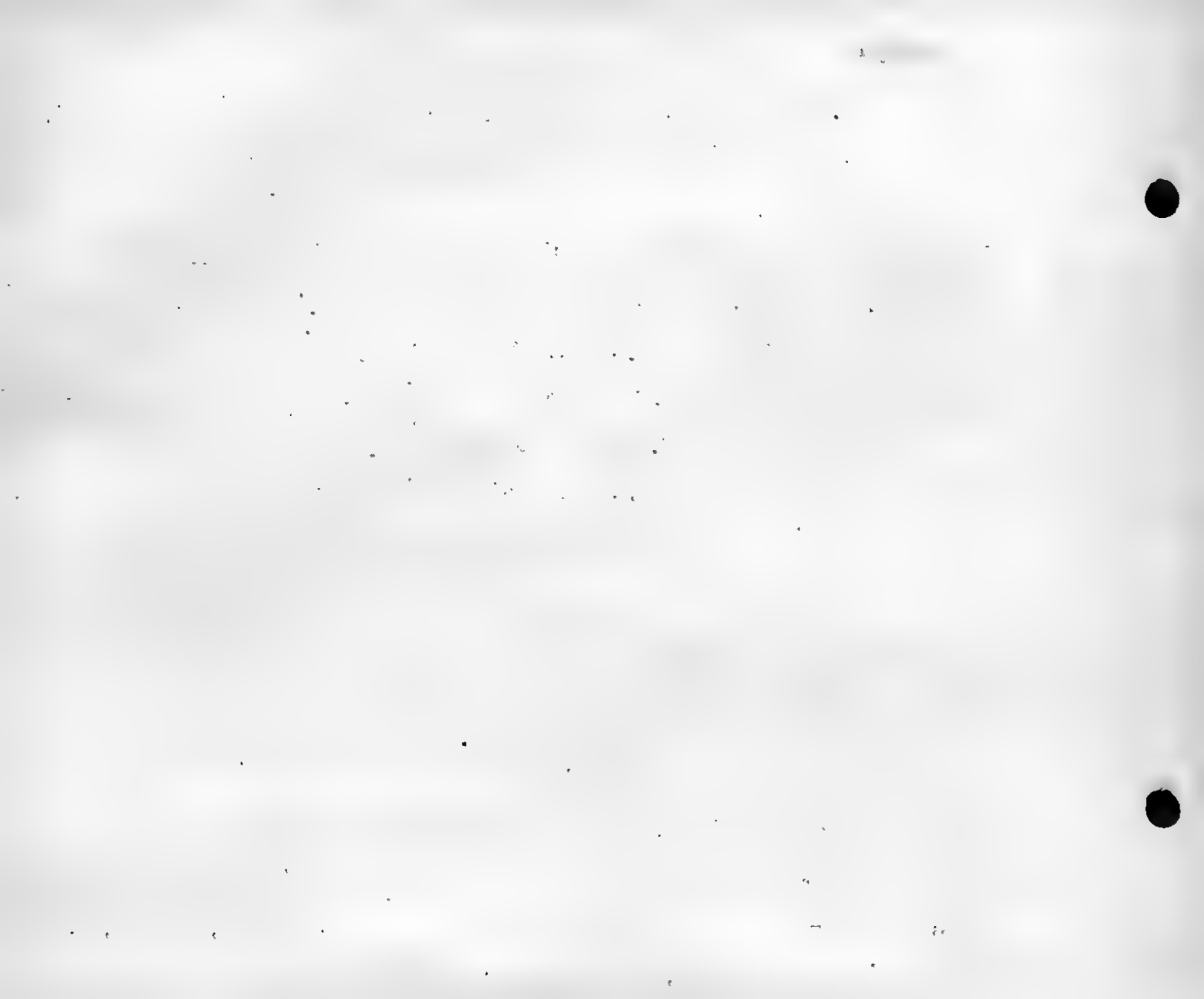
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then these remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03429

03423

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Se. Magdala Cahill</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>11</i> Year <i>69</i>			2b. HOUR <i>8 P</i> M	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>12-18-1888</i>		6 AGE (in years last birthday) <i>80</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md	
10 CITY OR TOWN OF DEATH <i>Glen Arm</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Glen Arm Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Glen Arm</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Glen Arm, Md.</i>		14 FATHER'S NAME First <i>Michael</i> Middle <i>Cahill</i> Last <i>Ells</i>		15 MOTHER'S MAIDEN NAME First <i>Stockett</i> Middle <i>Ells</i> Last <i>Stockett</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-54-2036</i>		17 INFORMANT <i>Dr. M. Kathleen</i>		Address <i>same</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1st</i> , 19 <i>68</i> , to <i>January 30</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>January 30th</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Henry L. McCorkle</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>3-12-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>HENRY L. MCCORKLE MD</i>		22e. ADDRESS <i>Phoenix Maryland 21131</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-14-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sisters Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Notch Cliff, Glen Arm, Md.</i>	
24. FUNERAL DIRECTOR <i>Raymond J. Curran</i>		ADDRESS <i>817 Scarlett Dr. Towson, Maryland 21204</i>		25a. RECD BY REGISTRAR DATE <i>21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03430 CERTIFICATE OF DEATH 03424									
1. DECEASED-NAME (Type or print) First Middle Last LENNA M CAMPBELL					2a. DATE OF DEATH 3 Month 9 Day 69 Year			2b. HOUR 11 ¹⁰ AM	
3. SEX FEMALE		4. RACE Cau		5. DATE OF BIRTH 4/15/91		6. AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Minn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Co. Md			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balt. Med. Cen.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Balt		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 18 E Hamilton St	
14. FATHER'S NAME First Middle Last William Campbell				15. MOTHER'S MAIDEN NAME First Middle Last Baldwin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Paul F. Due 516 Nottingham Rd Balt Md 29					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 460 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA of the TONSIL Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>69</u> , to <u>3/9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. Coralis MD					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/9/69		
22d. PHYSICIAN'S NAME (Type) D. CORALIS, M.D.					22e. ADDRESS 6701 N. Charles St. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/12/69		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Balt Co Md			
24. FUNERAL DIRECTOR Wm Cook-Brooks West Inc Balt Md 21228					25a. REC'D BY REGISTRAR DATE MAR 13 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03425							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF EST- DEATH MATED		2b HOUR M						
Thurman							Cantrell		3/8/69		6:45 M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year					
Male		White		Jan. 15, 1912		57 YRS.						March 8 1969					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.					
Virginia			U. S. A.						Baltimore								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Edgemere				7403 North Point Road				Warehouse - Bethlehem Steel Co.									
13a. USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
Maryland				Baltimore		Edgemere				7403 North Point Road							
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
J.			Elbert		Cantrell					Nettie			Rutherford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				(If yes give year or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)				ADDRESS			
Yes				1931-1934				401-01-7819		Mrs. Alma J. Cantrell				7403 North Point Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Acute Pulmonary Failure</u>																	
5159 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Miner's Disease</u>																	
(c) <u>Pneumoconiosis</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Rehabilitation</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				Theodore C. Patterson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/10/69					
EXAMINER'S NAME (Type)				Theodore C. Patterson				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3724 Dundalk Ave.					
								M.D. ADDRESS (Street, city, town, or county)				Dundalk, Md. 21222					
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				3/12/69		Balto. National Cemetery				Baltimore, Maryland							
24. FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John J. Duda, 7922 Wise Ave. Dundalk, Md.										MAR 11 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03432		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03426	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First MARION	Middle L.	Last CAREY	2a. DATE OF DEATH 3 Month 3-16-69 Day Year		2b. HOUR M
3. SEX FEMALE	4. RACE CAUCASIAN		5. DATE OF BIRTH 5/9/1897		6 AGE (in years lost in day) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Virginia	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 22 Acorn Circle	
14 FATHER'S NAME First Middle Last Ernest S. Harding			15 MOTHER'S MAIDEN NAME First Middle Last Judith				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 220-40-8376		17 INFORMANT Address -Mr. Thos. M. Carey, Jr.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c).)							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY AND CARDIAC FAILURE							
250- DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIAL PNEUMONIA AND ARTERIOSCLEROTIC HEART FAILURE							
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS WITH DIABETIC ACIDOSIS							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/15, 1969, to 3/16, 1969, that (I) (we) last saw the deceased alive on 3/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Barry R. Friedlander MD				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/16/69	
22d PHYSICIAN'S NAME (Type) DR. FRIEDLANDER				22e ADDRESS 6701 NORTH CHARLES STREET			
23a BURIAL, CREMATION, REMOVAL, (Specify)		23b DATE 3/19/69		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore	
24 FUNERAL DIRECTOR Mitchell Wedgwood Home Inc				25a REC'D BY REGISTRAR DATE 3/16/69		25b REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03433

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03427

1 DECEASED-NAME (Type or Print) <i>Elizabeth M Cavedo</i>				2a. DATE KNOWN OF ESTI-DEATH MATED <i>March 24 1969</i>				2b. HOUR <i>11 A</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Oct 13 - 1899</i>		6 AGE (In years last birthday) <i>79 YRS</i>		IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) <i>VA</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>BALTIMORE Co.</i>		2c DATE PRONOUNCED DEAD <i>March 24 1969</i>	
10 CITY OR TOWN OF DEATH <i>Towson Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St Joseph</i>		12a JSUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>SEAMSTRESS</i>		12b KIND OF BUSINESS OR INDUSTRY <i>FURIER</i>		2d HOUR <i>10 A</i>	
13a USUAL RESIDENCE (Where deceased lived, if not in institution Residence before admission) STATE <i>Md</i>		13b COUNTY <i>BALTIMORE</i>		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>406 Croydon Rd 21212</i>	
14. FATHER'S NAME First Middle Last <i>BENJAMIN BARKER</i>				15 MOTHER'S MAIDEN NAME First Middle Last <i>UNK.</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>218-03-2492</i>		17 INFORMANT <i>WILLIAM CAVEDO</i>		ADDRESS <i>406 Croydon Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i>								<i>3 Days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fracture of Right Ankle</i>								<i>4 Days</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>2nd Cast Application</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <i>8:00 A.M. March 20 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell out of Bed</i>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Living Home</i>		21f LOCATION Street or R.F.D. No <i>6000 Bellona Rd</i>		City or Town <i>Baltimore</i>		County <i>Baltimore</i> State <i>Md</i>	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Charles J. Donnell</i>				EXAMINER'S NAME (Type) <i>MD</i>				22b DATE SIGNED <i>3/24/69</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE <i>March 27 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Shirley's Home</i>		23d LOCATION (City or Town) (County) (State) <i>Baltimore Md</i>	
24 FUNERAL DIRECTOR <i>Frank H. ...</i>				ADDRESS <i>...</i>		25a REC'D BY REGISTRAR <i>...</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

03434										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03428																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First Middle Last ROSALIE A. CHARVAT										Month Day Year 9 31 69										1:19 PM																			
3 SEX FEMALE					4. RACE CAU					5. DATE OF BIRTH 3-25-98					6. AGE (In years last birthday) 71 YRS.					7. UNDER 1 YEAR MONTHS DAYS HOURS MIN					IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Balto.					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH BALTIMORE CO. Md																								
10. CITY OR TOWN OF DEATH TOWSON, MD.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GTR. BALTO. MED CNTR.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY									
13a. J.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.										13b. COUNTY Baltimore					13c. CITY OR TOWN U.S.A.					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 614 Elmwood Road 21206														
14. FATHER'S NAME First Middle Last Henry Borleis										15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Hildebrand																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 212-09-6371B					17. INFORMANT Address Thomas Charvat 614 Elmwood Road 21206																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAUSE OF BREAST WITH METASTASIS 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION 3-26-69 3-27-69										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FEMORAL ARTERY THROMBOSIS RGT ILIAC										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from March 26, 1969, to MARCH 31, 1969, that (I) (we) last saw the deceased alive on MARCH 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Bahram Eslami										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE SIGNED 3-31-69																			
22d. PHYSICIAN'S NAME (Type) BAHRAM ESLAMI										22e. ADDRESS 6701 NORTH CHARLES STREET																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 4-2-1969					23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith										23d. LOCATION (City or Town) (County) (State) Fullerton Baltimore Md														
24. FUNERAL DIRECTOR										ADDRESS Lassahn Funeral Home 7401 Belair Road 21236										25a. REC'D BY REGISTRAR APR 8 1969					25b. REGISTRAR'S SIGNATURE Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03435

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03429

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
William Albert Chenoweth						3 Month 20 Day 67 Year			11:00 P M		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		1-26-09		60 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.				Baltimore County			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown			Balto. Co. Gen. Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - H.W.T.S.P. YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Mary and				Baltimore		Pikesville		YES <input type="checkbox"/> NO <input type="checkbox"/>		4104 Milford Mill Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Arthur Chenoweth			Maude Drusey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>68</u> , to <u>March</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/19</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED		
<u>Philip Bernstein</u>									3/20/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
PHILIP BERNSTEIN			112 CHATTELLEY DR. REISTERSTOWN								
23a. BURIAL, CREMATION, ETC. (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>Buried</u>			<u>March 24, 1969</u>			<u>and Ridge Cemetery</u>			<u>Pikesville, Balto., Md.</u>		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>Frank J. Howell</u>			<u>Pikesville, Md.</u>			<u>MAR 26 1969</u>			<u>Julianus Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03436		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03430		
1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
Maud				M.		Chew	March Month 17 Day 1969	4:15 M
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	white		6-4-82		86 YRS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore	U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	St. Joseph Hospital		homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY L.M.T.S?	13e. STREET AND NUMBER				
Maryland	Balto.	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	210 E. Melrose Avenue				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Miller			Mattie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		220-09-8367		Son - John		same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive hemorrhage								
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)								
(b) Leaking aortic aneurysm								
(c) Arteriosclerotic cardiovascular disease.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> , 19 <u>69</u> , to <u>3-17-69</u> , that (I) (we) last saw the deceased alive on <u>3-17-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Benjamin DelCarmen</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-17-69</u>		
22d. PHYSICIAN'S NAME (Type) Benjamin DelCarmen, M.D.				22e. ADDRESS 7620 York Road, Towson, Md.				
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial	3/19/1969	Druid Ridge Cemt.		Pikesville Balto.		Md.		
24. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.				25a. REC'D BY REGISTRAR MAR 21 1969		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03437

CERTIFICATE OF DEATH

03431

1 DECEASED NAME (Type or print) Susie		First S.		Middle Clark		Last Clark		2a. DATE OF DEATH Month 3 Day 31 Year 69		2b. HOUR 8:35 P.M.	
3 SEX female		4. RACE Negro		5. DATE OF BIRTH Aug. 7, 1907		6. AGE (in years) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) domestic		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY, Y.M.T.S? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 916 Warren St.			
14. FATHER'S NAME George White		First George		Middle White		Last White		15. MOTHER'S MAIDEN NAME May Frances		First May Middle Fran Last ces	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO 218-12-2842D		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH MONTHS DUE TO, OR AS A CONSEQUENCE OF HEART FAILURE (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF YEARS (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9-17-68 , to 3-31-69 , that (I) (we) last saw the deceased alive on 3-31-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE 		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-31-69					
22d. PHYSICIAN'S NAME (Type) ALBERTO M. GUTIERREZ, MD		22e. ADDRESS SPRING GROVE STATE HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/4/69		23c. NAME OF CEMETERY OR CREMATORY Berkley		23d. LOCATION (City or Town) (County) (State) Darlington Md.					
24. FUNERAL DIRECTOR ROY O. WILSON		ADDRESS 2000 BANTLEY AVE		25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03438										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03432									
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Clarence Franklin Cobourn										Month 3 Day 14 Year 69										2 45 P M									
3 SEX			4. RACE			5. DATE OF BIRTH			6 AGE (In years lost birthday)			7 UNDER 1 YEAR			IF UNDER 24 HRS.														
m			W			1-17-1989			80 YRS			MONTHS DAYS			HOURS MIN														
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Md			U.S.A.						Baltimore Md																				
10. CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY											
Cockeysville						MARYLAND Masonic Home																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b COUNTY						13c CITY OR TOWN						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e STREET AND NUMBER					
Md						Baltimore						Baltimore						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						5701 Edmondson Ave.					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last																							
Hiram Cobourn						Lydia A. Cox																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown						16b SOCIAL SECURITY NO						17 INFORMANT Address																	
						218-0722874						Maryland Masonic Records																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Embolism cerebral.																		1 hr											
4125 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Vas. Heart Disease																		10 YRS.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC						21f LOCATION Street or R.F.D. No City or Town County State																	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE Carl F. Benson MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																		22c DATE SIGNED March 14, 1969											
22d PHYSICIAN'S NAME (Type) Carl F. Benson MD																		22e. ADDRESS											
23a BURIAL, CREMATION, REMOVAL (Specify)						23b DATE						23c. NAME OF CEMETERY OR CREMATORY						23d LOCATION (City or Town) (County) (State)											
Burial						3-18-69						St Thomas						Baltimore Co Md.											
24. FUNERAL DIRECTOR 622 BALTO NA - Pike BALTIMORE MD.																		25a REC'D BY REGISTRAR DATE MAR 18 1969				25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03439		CERTIFICATE OF DEATH						03433	
1 DECEASED NAME (Type or print) Harry Cohen			2a. DATE OF DEATH Month 3 Day 29 Year 1969			2b. HOUR 12:15 PM			
3 SEX MALE		4 RACE White		5 DATE OF BIRTH 7-8-1889		6 AGE (in years last birthday) 79 YRS		7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH CATONSVILLE (Balto)		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove S. Hosp		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) PROFESSIONAL		12b KIND OF BUSINESS OR INDUSTRY BOXER			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 141 W. Wolfe St	
14 FATHER'S NAME First Abraham Middle Cohen Last Cohen			15 MOTHER'S MAIDEN NAME First Eva Middle SADOWSKI Last SADOWSKI						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b SOCIAL SECURITY NO. 219-54-3075		17 INFORMANT MRS. SADIE METZGER		Address 9011 BRUNO RD. RANDALLSTOWN			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Card. Vasc disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 12-30 , 19 69 , to 3-29 , 19 69 , that (I) (we) last saw the deceased alive on 3-29 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Narciso W. Carmona MD		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 3-29-69			
22d PHYSICIAN'S NAME (Type) NARCISO W. CARMONA		22e ADDRESS Spring Grove S. Hosp.							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4-2-69		23c NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH (AITZ CHAIM)		23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a REC'D BY REGISTRAR DATE APR 3 1969		25b REGISTRAR'S SIGNATURE Charles Judge			

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03440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03434

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First Albert		Middle F.		Last Conklin Sr.		2a DATE KNOWN OF DEATH Month Day Year 3-3-1969		2b HOUR 10:00 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 6/14/24	6 AGE (In years) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year March 3, 1969		2d HOUR 10:00 AM	
7a BIRTHPLACE (State or foreign country) North Carolina		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3005 Wells Road				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Welder Bethlehem Steel Co.		12b. KIND OF BUSINESS OR INDUSTRY			
13a USLA RESIDENCE (Where deceased lived, if institution residence before adm ssion) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Edgemere		3d. INSIDE CITY - HITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3005 Wells Road			
14. FATHER'S NAME First Middle Last ? ? ?		15. MOTHER'S MAIDEN NAME First Middle Last ? ? ?									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 241-28-9810		17. INFORMANT (Wife) Mrs. Ruth B. Conklin, 3005 Wells Rd.		ADDRESS Edgemere, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GUN SHOT WOUND THRU LEFT</u> 155X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHEST - (HEMAT) 12 GA -</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 9:30 AM 3-3-1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot and hit with shot gun							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, and so on, etc.) Home		21f LOCATION: Street or R.F.D. No 3005 Wells Road - 80419-Bald-Md		City or Town Baltimore		County Baltimore		State Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Melvin B. Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/4/69 6800 Mornington Rd. Dundalk, Md. 21222	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/6/69		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS		25a REC'D BY REGISTRAR MAR 6 1969		25b REGISTRAR'S SIGNATURE [Signature]			

03441

CERTIFICATE OF DEATH

03435

1. DECEASED-NAME (Type or print) Elmer		First	Middle	Last	2a. DATE OF DEATH Month March Day 11 Year 1969		2b. HOUR 8:15 M
3 SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 1, 1912			6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7328 Manchester Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Crane Repairman-Bethlehem Steel Co.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	3c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7328 Manchester Road			
14. FATHER'S NAME First John	Middle W.	Last Cooke	15. MOTHER'S MAIDEN NAME First Anna		Middle 	Last Mitch	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213-07-0199		17. INFORMANT (wife) Mrs. Helen V. Cooke, 7328 Manchester Rd. Address Dundalk, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Glioblastoma multiforme 1969 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July , 19 1954 to 3/10/69 , 19____, that (I) (we) lost saw the deceased alive on 3/10 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. S. Magno				DEGREE M.D.		22c. DATE SIGNED March 13, 1969	
22d. PHYSICIAN'S NAME (Type) Raymundo Magno		22e. ADDRESS 1012 Old North Point Rd. Balto. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE MAR 14 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATE ON

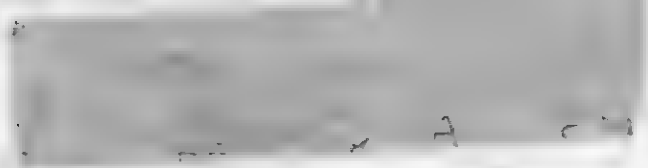
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 4 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03442		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03436	
Item # 3, Film 410 3/27/69		CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or print) CHARLES A COOKSON		First Middle Last		2a DATE OF DEATH MAR Month 17 Day 69 Year		2b HOUR M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 5-2-1908		6 AGE (In years lost birthday) 60 YRS	
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATE <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH Cockeysville		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Bonnie Blink Hope		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MAINTENANCE		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE MD		13b COUNTY -		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 612 HYSON ST.		14 FATHER'S NAME First Middle Last Wm. M. Cookson		15 MOTHER'S MAIDEN NAME First Middle Last Annie (Saunders)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No. (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 217-09-7666		17 INFORMANT MASONIC HOME - RECORDS		Address	
18 CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Vas. Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4514 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 hr. 5 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January 14 , 19 69 , to March 17 , 19 69 , that (I) (we) last saw the deceased alive on March 17 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Carl F. Johnson M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED MAR. 17 1969			
22d. PHYSICIAN'S NAME (Type) Carl F. Johnson M.D.				22e. ADDRESS 5111 York Rd. Balt. Md 21212			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-20-69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Haven, AR Md.	
24. FUNERAL DIRECTOR McCully - 130 E Fort Ave. Balt. Md. 21230		25a. RECD BY REGISTRAR MAR 18 1969		25b. REGISTRAR'S SIGNATURE James J. Jackson			



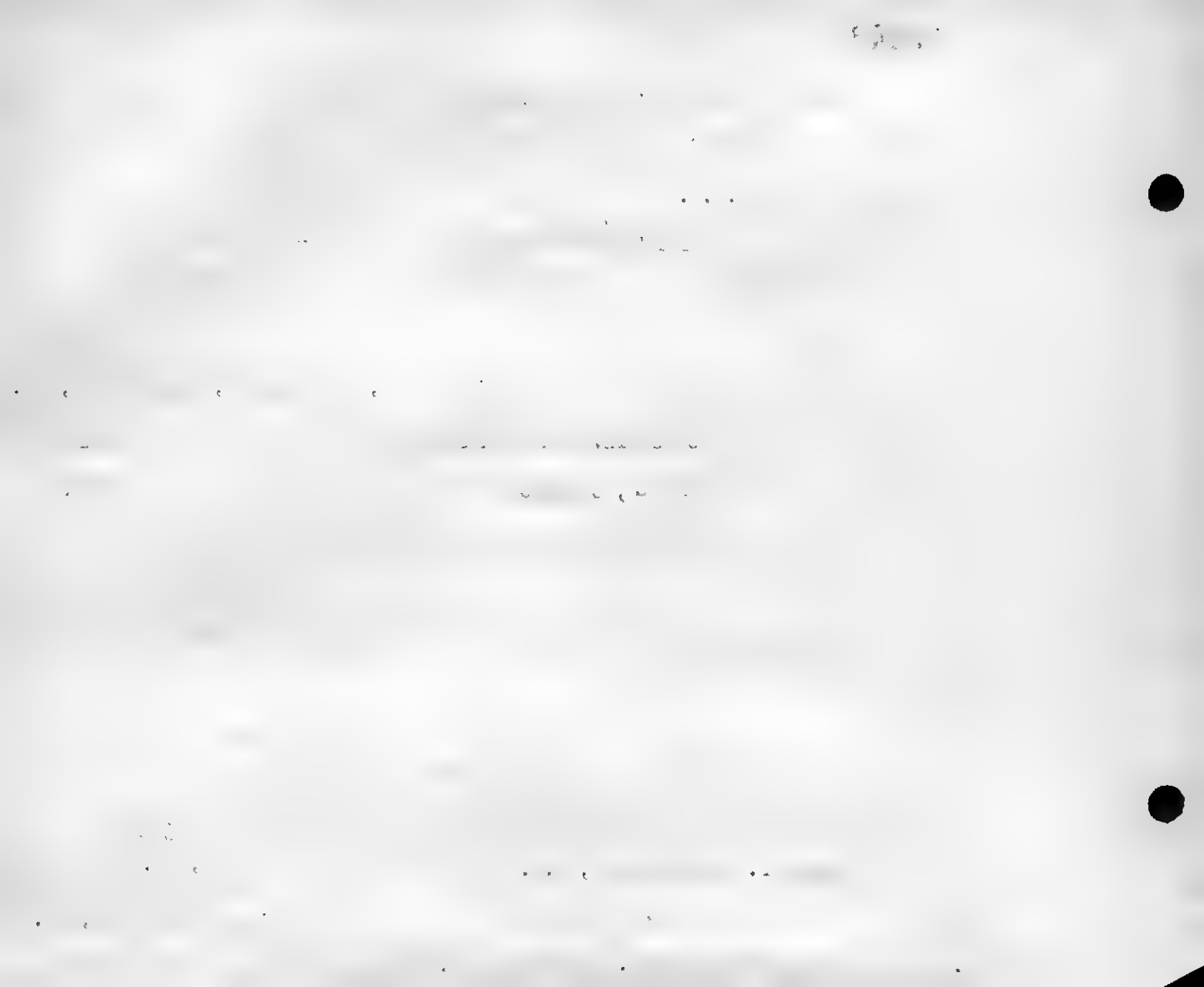
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

03443		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03437	
1 DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last WILLIAM ERNEST CORNISM				March Month 28 Day 1969		3:05 PM	
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 8/18/01		6 AGE (in years last birthday) 67 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cab Driver		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE MARYLAND DORCHESTER		13c CITY OR TOWN CAMBRIDGE		13d INS OF CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 617 Pine Street	
14 FATHER'S NAME First Middle Last SAMUEL CORNISM				15 MOTHER'S MAIDEN NAME First Middle Last MARTHA JENNIFER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO WW-1 220 12 24 43		17 INFORMANT Address Clinical Rcds, VA Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE							
DUE TO, OR AS A CONSEQUENCE OF (b) UREMIA, CHRONIC							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Mar 17 , 1969, to Mar 28 , 1969, that (I) (we) last saw the deceased alive on Mar 28 , 1969, and that in 60x (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) 200x view the body after death							
22b. SIGNATURE Madhav S. Barhanpurkar		22c. DATE SIGNED 3/29/69		22d. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.			
22e. ADDRESS VA Hospital, Fort Howard, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/1/69		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge-Dorchester, Md.	
24. FUNERAL DIRECTOR St. Clair Funeral Home, High St. Cambridge, Md.				25a. REC'D BY REGISTRAR APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 10
304 RE

03444

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03438

1. DECEASED NAME (Type or print) Charles Philip Croney			2a. DATE OF DEATH 3 Month 12 Day 69 Year			2b. HOUR 3:05 a M			
3 SEX Male		4. RACE Cau		5. DATE OF BIRTH 7/2/09		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 15 BOX 15	
14 FATHER'S NAME First Middle Last PHILLIP CRONEY			15. MOTHER'S MAIDEN NAME First Middle Last MARY ZUELLINGER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17 INFORMANT CATHERINE MAJORS		Address RT 15 BOX 15			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Widespread metastases and bronchopneumonia 1617 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of larynx DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/24, 19 69, to 3/12, 19 69, that (I) (we) last saw the deceased alive on 3/11, 19 69, and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rudiger Breiteneker, M.D.				DEGREE ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/12/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/15/69		23c. NAME OF CEMETERY OR CREMATORY PARK WOOD		23d. LOCATION (City or Town) (County) (State) BALTO. M.D.			
24. FUNERAL DIRECTOR J.E. CONNELLY SONS				ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DATE MAR 14 1969		25b. REGISTRAR'S SIGNATURE O'Donoghue Judge	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 414 Maryland State Department of Health
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
03445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03439

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
TINA		Ann	DALCIN		3 25 19 69		9:05 PM
3 SEX	4. RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Year 19	
Female	White	1/26/1969		59 YRS.	7 59	March 25, 19 69 9:05 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Baltimore		USA				Balto. Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Towson		Greater Balto. Med. Center				Babe DunHome	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER	
MD.		Balto.		Balto.		6849 McClean Blvd. (Parents)	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Stephen Edward Dalcin		Karen Denise Wilmeth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17 INFORMANT ADDRESS			
No		None		Family records			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Death following intravenous injection</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>of Conray - 400 (Sodium iothalamate)</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. P.M. 3 25 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
CAUSE OF DEATH				Therapeutic misadventure			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
				Towson		Balto Md.	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EDWARD F. WILSON, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		3/26/69	
EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Mar. 27, 1969		Druid Ridge Cemetery		Pikesville, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE	
John Burns' Sons, Towson, Maryland				MAR 28 1969		Charles V. ...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03446		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03448	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
TRUMAN J. DAVIS				Month 3 Day 16 Year 69		4:45 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	
MALE		CAUCASIAN		10/10/09		59 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				BALTIMORE Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		G.B.M.C.		Carpenter			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Carroll		Sykesville		Rural	
14. FATHER'S NAME First Middle Last		15. MOTHER'S M A DEN NAME First Middle Last					
Atlee Davis		Goldie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of serv ce)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		215-18-1141		Dalton A. Davis 3330 Orutt Rd. Randallstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA							
DUE TO, OR AS A CONSEQUENCE OF							
(b) CHRONIC ABSTRACTIVE PULMONARY DISEASE							
DUE TO, OR AS A CONSEQUENCE OF							
(c) CORPULUINIALE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/13, 1969, to 3/16, 1969, that (I) (we) last saw the deceased alive on 3/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		6701 NORTH CHARLES STREET		3/16/69			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3/19/1969		Bethel Cemetery		Carroll, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C. M. Waltz, Box 241, Sykesville, Md.				MAR 19 1969			

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03447

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03441

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
PAUL		J.	DEBRING	MARCH	25	1969	5:00A	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		JULY 21, 1894		74 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH		
Illinois		U.S.A.		BALTIMORE		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON		St. JOSEPH HOSPITAL		Bus Driver		Transit		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY - MTS?		13e STREET AND NUMBER
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		813 C LENTON AVE.		#21212
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		Address				
First Middle Last		First Middle Last						
UNKNOWN		UNKNOWN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT				
YES		WW 1		Mrs. Sadie Price 5218 Biddison Lane				
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Ischemia								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 15, 1969, to March 25, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 25, 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did/did not) view the body after death								
22b SIGNATURE N. Kunawongsa				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED March 25, 1969		
22d PHYSICIAN'S NAME (Type) Nit Kunawongsa, M.D.				22e ADDRESS 7620 York Road Towson, Md. #21204				
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		27 MAR 69		Woodlawn Cemetery		Baltimore, Maryland 21207		
24 FUNERAL DIRECTOR J. L. Lowell Lemmon				ADDRESS 4611 Park Heights Avenue		25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE MAR 27 1969

VR 111
45M

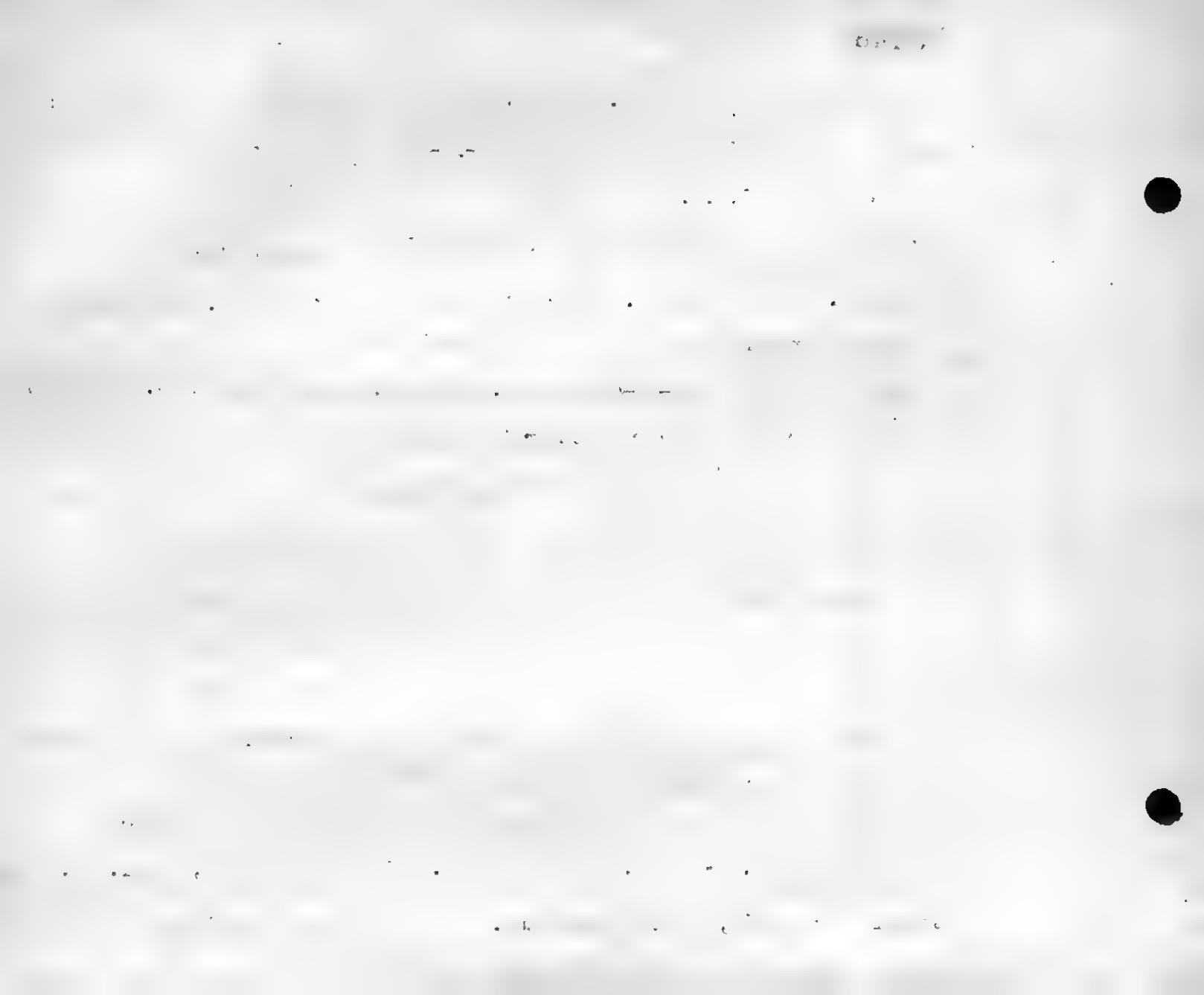


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VR A 151
30M REV

03448		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03442	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) LOUISA		First Middle Last K. DENHARD		2a. DATE OF DEATH March Month 9 Day 1969 Year		2b. HOUR 8:35PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-12-80		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COLLEGE MANOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME August Shrader		First Middle Last		15. MOTHER'S MAIDEN NAME Amelia Rost		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-32-4591		17. INFORMANT Mr. August A. Denhard	
				Address Winans Rd. Randallstown			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis							36 Hours
4339 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis							5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 2/13/65 , 19 65 , to March 9 , 19 69 , that (I) (we) saw the deceased alive on March 9 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE William F. Fritz M.D.				22c. DATE SIGNED 3/9/69			
22d. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ, M.D.				22e. ADDRESS 2 W. University Parkway, Balt., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 12, 69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Maus.		23d. LOCATION (City or Town) (County) (State) Windsor Mill Road	
24. FUNERAL DIRECTOR Loring Byers				25a. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE	
ADDRESS 8728 Liberty Road Randallstown							

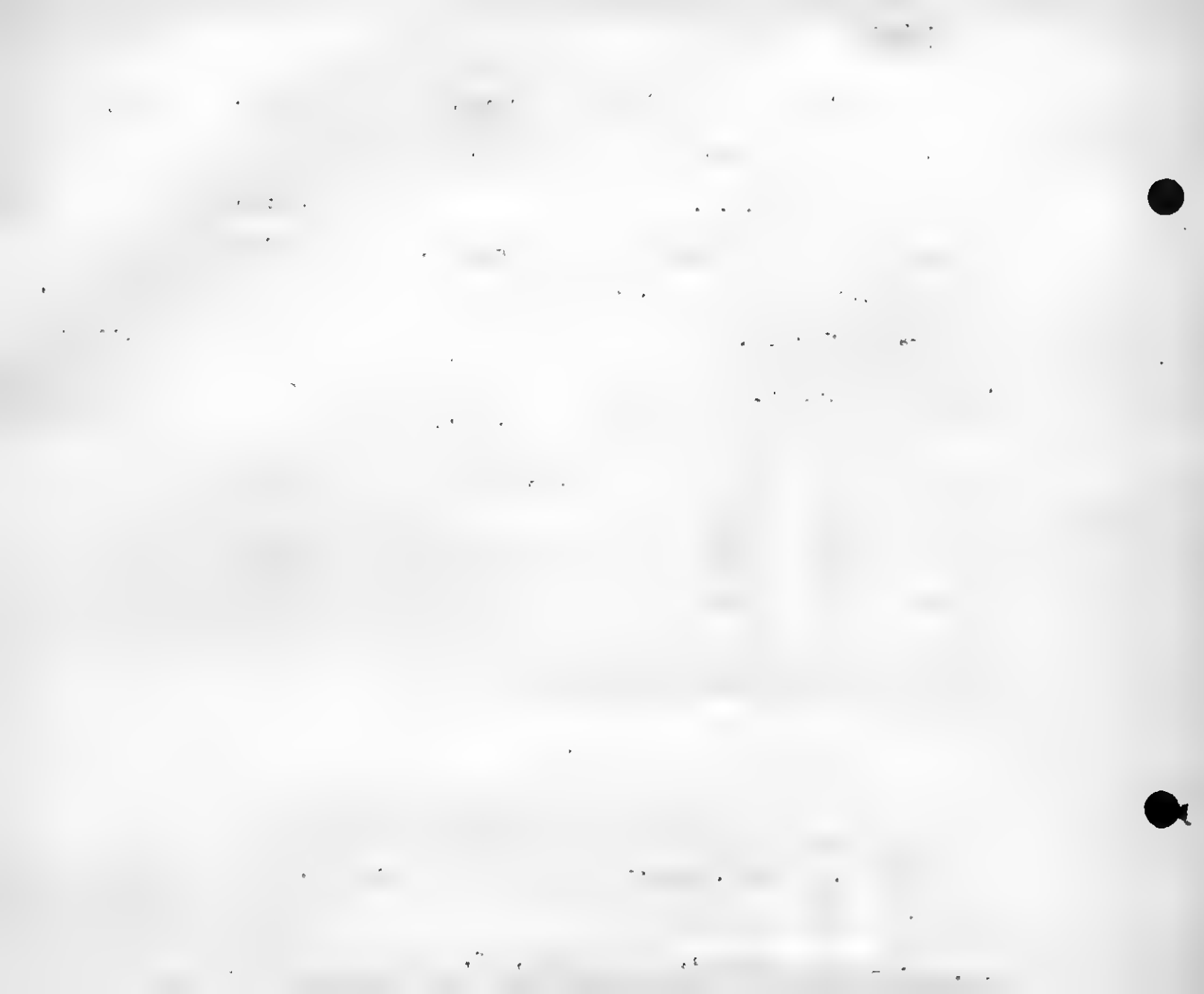


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VR A15
304 REV 1-68

03449		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03443	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) John Harvey Denton			2a. DATE OF DEATH Month March Day 20 Year 1969			2b. HOUR M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Sept. 12, 1918		6. AGE (n years last birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson Nursing H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Vice President		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. USUAL RESIDENCE (Where deceased lived, if instituton Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10303 Malcolm Circle Apt. F		14. FATHER'S NAME First Harvey Middle Ward Last Denton		15. MOTHER'S MAIDEN NAME First Marie Middle McGinnis Last McGinnis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. W.W. Two 212016-6352		17. INFORMANT Patricia Denton, Same as # 13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 1621 IMMEDIATE CAUSE (a) Cerebral Metastases DUE TO, OR AS A CONSEQUENCE OF Bronchial Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sun, 1969 , to 3.20, 1969 , that (I) (we) last saw the deceased alive on 3.19. 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. Manley				DEGREE PHYS ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Dr. Keith A. Manley				22e. ADDRESS 2045 York Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Mar. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc Towson, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 24 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03450

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03444

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF EST- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR M		
MARCEL			DE VELEZ			19			M		
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR P. M.		
male	white	Sept. 1, 1899.	69 YRS			March 24 1969			10:15 P. M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
California		USA				Baltimore Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto Med Center			Radio Officer (Merchant Marine)					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. STREET AND NUMBER			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Baltimore			610 Doochick Road			Dunkirk		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Unknown			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW2			Unk.			Mrs. Effie A. DeVelez (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR MIN 5:00 P.M. 3/20/ 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subj. attempted to hang himself - rope broke and he fell downstairs					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home			21f. LOCATION Street or RFD No. City or Town County State Baltimore, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 3/25/69		
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial Cremation			3/26/69			Greenmount Crematory			Baltimore, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Balto. Md. 21214						MAR 26 1969			Charles Judge		

03451

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Margaret		First Middle Last		2a. DATE OF DEATH Month 5 Day 2 Year 1969		2b. HOUR M	
3. SEX Female		4 RACE Cau.		5. DATE OF BIRTH 3-22-1882		6 AGE (In years last birthday) 86 YRS	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH White Marsh Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 441B White Marsh		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN White Marsh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Joseph Kraft		First Middle Last		15. MOTHER'S MAIDEN NAME Catherine Kahl		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 213-36-8401D		17. INFORMANT John J. Dieter		Address 441B White Marsh Rd 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 4 - X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Atherosclerosis, Coronary artery disease, & left heart disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July , 19 68 , to 3-2 , 19 69 , that (I) (we) last saw the deceased alive on 3-1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John C. Hyle		DEGREE JOHN C. HYLE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-3-69	
22d. PHYSICIAN'S NAME (Type) JOHN C. HYLE		22e. ADDRESS 7527 Belair Rd Balt. 21236					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-5-1969		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Road 21236		25a. REG. BY REGISTRAR MAR 5 1969		25b. REGISTRAR'S SIGNATURE John J. Dieter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

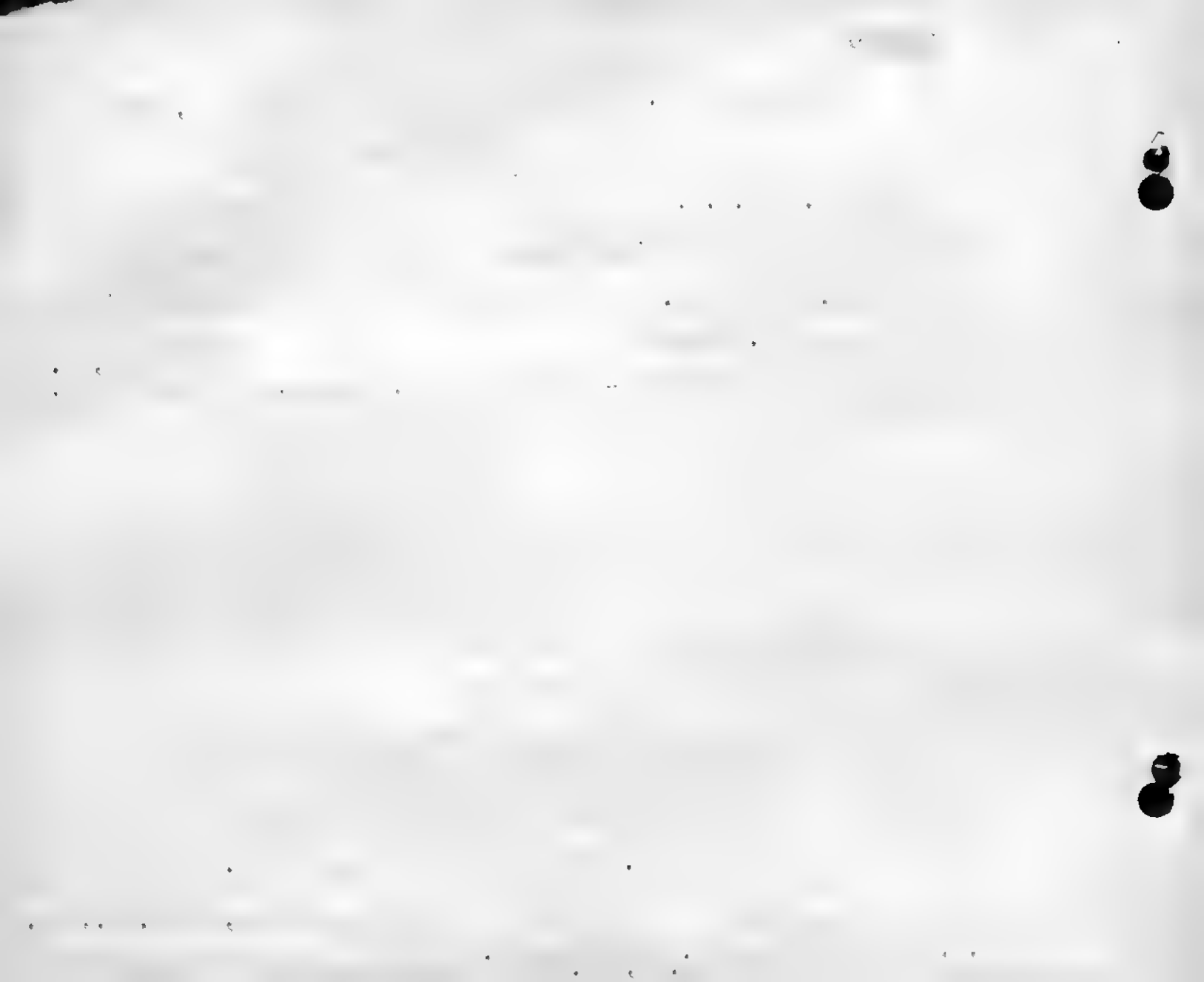
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03452		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03446	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Edward J. Donaghy					March 29, 1969		7:30 P M
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
M	W		9/30/1904		64 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Balto. Md.		U.S.A.				Baltimore Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkridge Estates		6 Overidge Court		Retired Conductor B&O RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Balto.		Elkridge Estates		6 Overidge Court	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		17. INFORMANT	
Robert J. Donaghy		Molly Rogers		No		Austin X. Dopman, 1501 Dunlora Rd. Suxtony, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		18b. SOCIAL SECURITY NO		18c. COUNTY		18d. CITY OR TOWN	
PART 1 DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Lung		A-705-05-5087					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 17 May, 19 67, to March 19 69, that (I) (we) saw the deceased alive on March 29 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
Dr. William G. Helfrich		3-31-69		Dr. William G. Helfrich		5006 Roland Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4/1/1969		Parkwood		Parkville, Balto. Co., Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		APR 1 1969		Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, and item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

03453 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03447	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) Edward Neal Drexel			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Mar 19 1969			2b HOUR 8 PM		
3 SEX Male		4 RACE W		5 DATE OF BIRTH 7 Oct 1915		6 AGE (In years and months) 53 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c DATE PROHOUNCED DEAD Month Day Year Mar 19 1969	
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE			Md.		
10 CITY OR TOWN OF DEATH BALTO (evening)		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8314 A Nunley Dr. Millwright		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Steel Co.		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 8314 A Nunley Drive			
14 FATHER'S NAME First Middle Last Edward B. Drexel			15 MOTHER'S MAIDEN NAME First Middle Last Maude M. Harvey								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.		(If yes give war or dates of service)		16b SOCIAL SECURITY NO. 212-07-8007		17 INFORMANT Mrs. Rose L. Drexel			ADDRESS (Same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Dissecting Aneurysm (c) Cardiac Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undert.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John C. Hyle				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 3-14-69			
EXAMINER'S NAME (Type) JOHN C. Hyle				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county) 7527 Belton Rd Baltimore Md 21236							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/24/69.		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a REC'D BY REGISTRAR MAR 20 1969		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

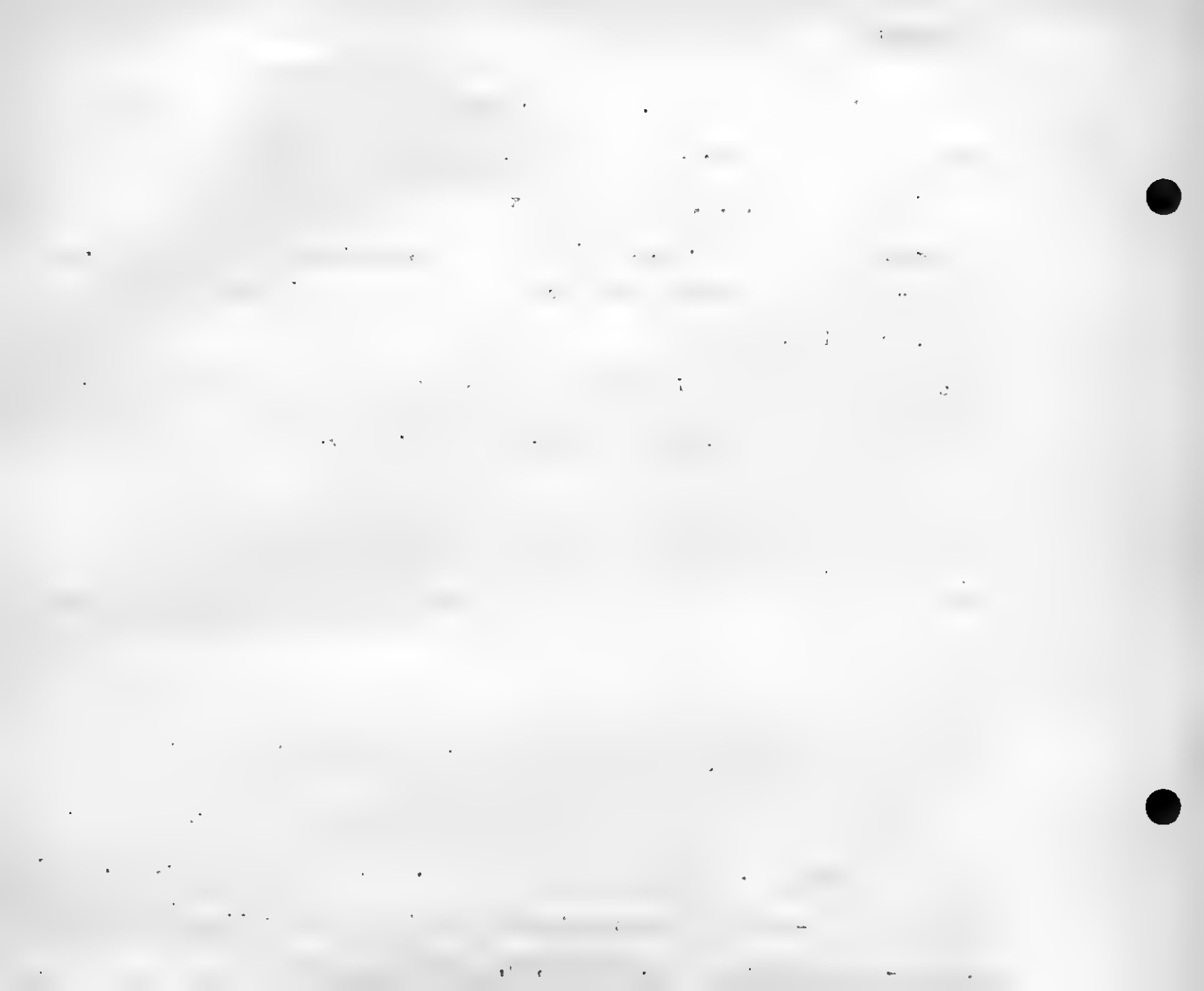
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03454 CERTIFICATE OF DEATH 03448									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b HOUR
Louise Lee Drisgill						Month Day Year March 10, 1969			M
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		March 17, 1884			84 YRS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Co., Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore 21204			8409 Loch Raven Blvd.			Buyer		Dept. Store	
13a. US. AL. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore		21204		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8409 Loch Raven Blvd.
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Thomas Drisgill			Belle Ann Weidman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOC. A. SECURITY NO		17 INFORMANT Address				
No					James A. Gide 612 Piper Rd. 21136				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>									<u>Sudden</u>
4104 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Arteriosclerotic CVD</u>									<u>1 year</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from Oct 1968, to March 10, 1969, that (I) (we) last saw the deceased alive on March 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph F. LiPira MD</u>					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/12/69.		
22d. PHYSICIAN'S NAME (Type) Joseph F. LiPira					22e. ADDRESS 8400 Loch Raven Blvd. Balto., Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-13-69		Loudon Park Cem		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. AREA BY REGISTERED		25b. (REGISTERED SIGNATURE)		
Wm. E. Johnson 8521 Loch Raven Blvd. 21204					MAR 17 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Tilen please remove carbon pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03455		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03449	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
NAN		R.		DU BRUL	March 15 1969		10:30 AM
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Caucasian		3-13-1879		90 YRS.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Kentucky		U.S.A.		Baltimore		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		620 Lake Drive		Practical Nurse		Nursing	
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore		Towson		13e STREET AND NUMBER	
						620 Lake Drive	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
William Thomas McDaniel					Margaret Johnston		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT			
No		270-30-3289		Paul Bilger 620 Lake Drive, Towson, Md. 21204			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>							10+ years
4123 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>Gastritis, Esophagitis, Stomatitis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natily medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year					
		P.M. 19					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
				Street or R.F.D. No.			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Mar 15</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>Mar 13</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>Charles E. Shaw, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<u>Mar 15, 1969</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Charles E. Shaw				607 W. Joppa Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3-17-69		Dulaney Valley Memorial		Cockeysville Maryland	
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR	
Wm. Cook-Brooks Towson, Inc. Towson, Md.						MAR 17 1969	
						25b. REGISTRAR'S SIGNATURE	
						<u>Wm. Cook-Brooks</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03456

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03450

1. DECEASED-NAME (Type or print) <i>Richard</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>11</i> Day <i>12</i> Year <i>1969</i>		2b. HOUR <i>11</i> M	
3 SEX <i>Male</i>	4 RACE <i>Caucasian</i>		5 DATE OF BIRTH <i>11-14-1917</i>		6 AGE (In years last birthday) <i>51</i> YRS.		IF UNDER 1 YEAR MONTHS <i>11</i> DAYS <i>12</i>	IF UNDER 24 HRS HOURS <i>11</i> MIN <i>00</i>
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>United States</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md		
1d. CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph's Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased was at time of death) <i>Baltimore</i> STATE <i>Md</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>1212</i>
14 FATHER'S NAME <i>Freeman</i>		First	Middle	Last	15 MOTHER'S MAIDEN NAME <i>Matthew</i>		First	Middle Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO <i>1-1-2</i>		17 INFORMANT <i>Dr. J. D. Matthews</i>		Address <i>1212</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Supine for</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Heart attack</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic coronary artery disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>11/11/69</i> to <i>11/12/69</i> , that (I) (we) last saw the deceased alive on <i>11/11/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>E. Trajillo</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11/12/69</i>
22d. PHYSICIAN'S NAME (Type) <i>E. Trajillo</i>				22e. ADDRESS <i>1212</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>11/12/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park</i>		23d LOCATION (City or Town) (County) (State) <i>Maryland</i>		
24 FUNERAL DIRECTOR <i>Stewart</i>				25a REC'D BY REGISTRAR <i>11/12/69</i>		25b REGISTRAR'S SIGNATURE <i>11/12/69</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03457

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03451

1. DECEASED NAME (Type or print) Frank		First Michael		Middle Dull		Last		2a. DATE OF DEATH Month Day Year March 16 69				2b. HOUR 5.42 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-29-1889				6. AGE (In years lost birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md							
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1600 Orlando Road-21234					
14. FATHER'S NAME First Middle Last Michael Dull		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Junker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (No known)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-10-64024		17. INFORMANT Address Mrs Amelia Long 1600 Orlando Road 21234									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic-cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>2/14/</u> , 1969, to <u>3/16/</u> , 1969, that (I) (we) last saw the deceased alive on <u>3/16/</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Antonio H. de Leon M.D.</u>		DEGREE M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-16-69			
22d. PHYSICIAN'S NAME (Type) Antonio deLeon M.D.		22e. ADDRESS 6620 York Rd., Towson, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-20-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City or Town) Parkville		(County) Balto.		(State) Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				25a. REC'D BY REGISTRAR DATE MAR 21 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03458

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03452

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b HOUR
Blanche			Louise	Durham	OF ESTI- DEATH MATED <input type="checkbox"/> <u>March 22</u> 1969		5:30 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	F UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	June 11, 1895	73 YRS			March 22 1969	M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Md	
D.C. Washington,	U.S.A.		Baltimore				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore 7		3508 Sedgemoor Rd. Baltio.		Retired		Bendix Corp.	
13a USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Md.		Baltimore	Baltimore		3508 Sedgemoor Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Edgar O. Dix			Ella Minis				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
NO		None		Baltimore 7, Md. Mr. Frederick L. Miller, 3508 Sedgemoor Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of Breast</u>							
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		22b. DATE SIGNED	
<u>J. Nelson McKay</u>						<u>March 22, 1969</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 25, 1969	Lorraine Park Cemetery		Woodlawn Baltio., Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
<u>Frank H. Newell</u>		<u>Pikesville 8, Md.</u>		MAR 26 1969		<u>Charles Juerga</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, with in 72 hours after death.

SHIPPED TO: LOWNDES FUNERAL HOME, ATLANTA GEORGIA.

03459										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03453																																							
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b. HOUR A																																							
First Middle Last										Month Day Year										9:10 M																																							
CHARLES ANDREW ELLENBURG										March 20 1969																																																	
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (in years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
Male										White										4/4/97										71 YRS																													
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md																			
GEORGIA										U.S.A.																				BALTIMORE																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR PLACE WHERE DECEASED DIED (Give street address)										12a USUAL OCCUPATION (Kind of work done during usual working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
FORT HOWARD										Administration Hospital										CLERK										MOVING CO.																													
13a USUAL RESIDENCE (Where deceased lived, admission) STATE										13b COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER																			
MARYLAND																				BALTIMORE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20 S. ARLINGTON AVENUE																			
14. FATHER'S NAME First Middle Last										15 MOTHER'S MAIDEN NAME First Middle Last																																																	
RANSOME										ELLENBURG										ELIZABETH										REED																													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or dates of service)										16b SOCIAL SECURITY NO										17 INFORMANT Address																																							
Yes										WW-1										213 20 5500										Clinical Recs VA Hospital, Fort Howard, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										RIGHT MIDDLE LOBE PNEUMONIA										APPROX. MAX. INTERVAL BETWEEN ONSET AND DEATH										24 hrs.																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause										(b) OR AS A CONSEQUENCE OF OBSTRUCTIVE PULMONARY EMPHYSEMA										Years																																							
(c) OR AS A CONSEQUENCE OF COR-PULMONALE																				Years																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21b. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC										21c LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (this hospital) attended the deceased from March 4, 1969, to Mar. 20, 1969, that (we) last saw the deceased alive on Mar. 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b SIGNATURE										DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c DATE SIGNED										3/21/69																													
22d PHYSICIAN'S NAME (Type) R. G. MIRO, M.D.										22e ADDRESS										VA Hospital, Fort Howard, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										Mar/ 21, 1969										Church Cemetery										Dawson County, Atlanta, Ga.																													
24 FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																													
										4210 Belair Rd. Balto, Md.										DATE MAR 24 1969										J. C. L. Judge																													
ULLRICH FUNERAL HOME																																																											

03460

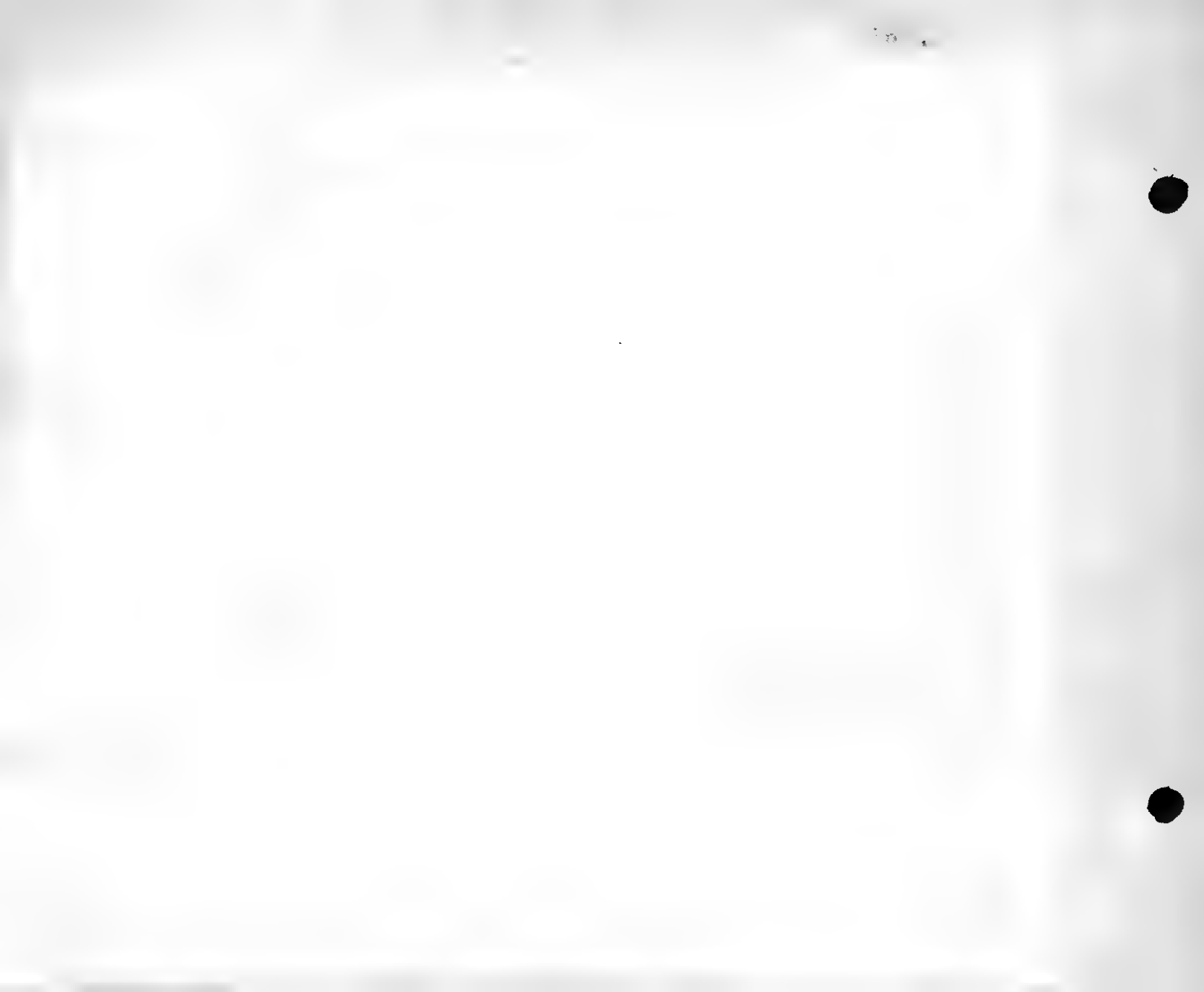
CERTIFICATE OF DEATH

03454

1. NAME OF DECEASED (Type or Print) ALBERT ELLIOTT		2. DATE AND HOUR OF DEATH MARCH 12-1969 11:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BALTIMORE COUNTY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FOREST HAVEN NURSING HOME 315 INGLISIDE AVE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 18, 1892	
9. AGE (in years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CREDIT MANAGER	
11. BIRTHPLACE (State or foreign country) BALTO., MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY ELLIOTT		14. MOTHER'S MAIDEN NAME MARGARET WOLFF	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W. WI		16. SOCIAL SECURITY NO. 215-05-4366	
17. INFORMANT MRS. FLORAM ELLIOTT		ADDRESS 5452 WHITWOOD RD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHITIS - CHRONIC CHRONIC LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HEART DISEASE A. B. V. D.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about) 21C. WHERE DID (if in Baltimore City, give exact location)	
23A. SIGNATURE Flora M. Elliott		23B. DATE SIGNED 3/12/69	
23C. PHYSICIAN'S NAME (Type) Flora M. Elliott		23D. ADDRESS 5452 WHITWOOD RD. BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-15-69	
24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY		24D. LOCATION (City, town, or county) (State) TAYLOR AVE, BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1969		25B. NAME OF REGISTRAR Charles Judge	
25C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 BELAIR RD.	

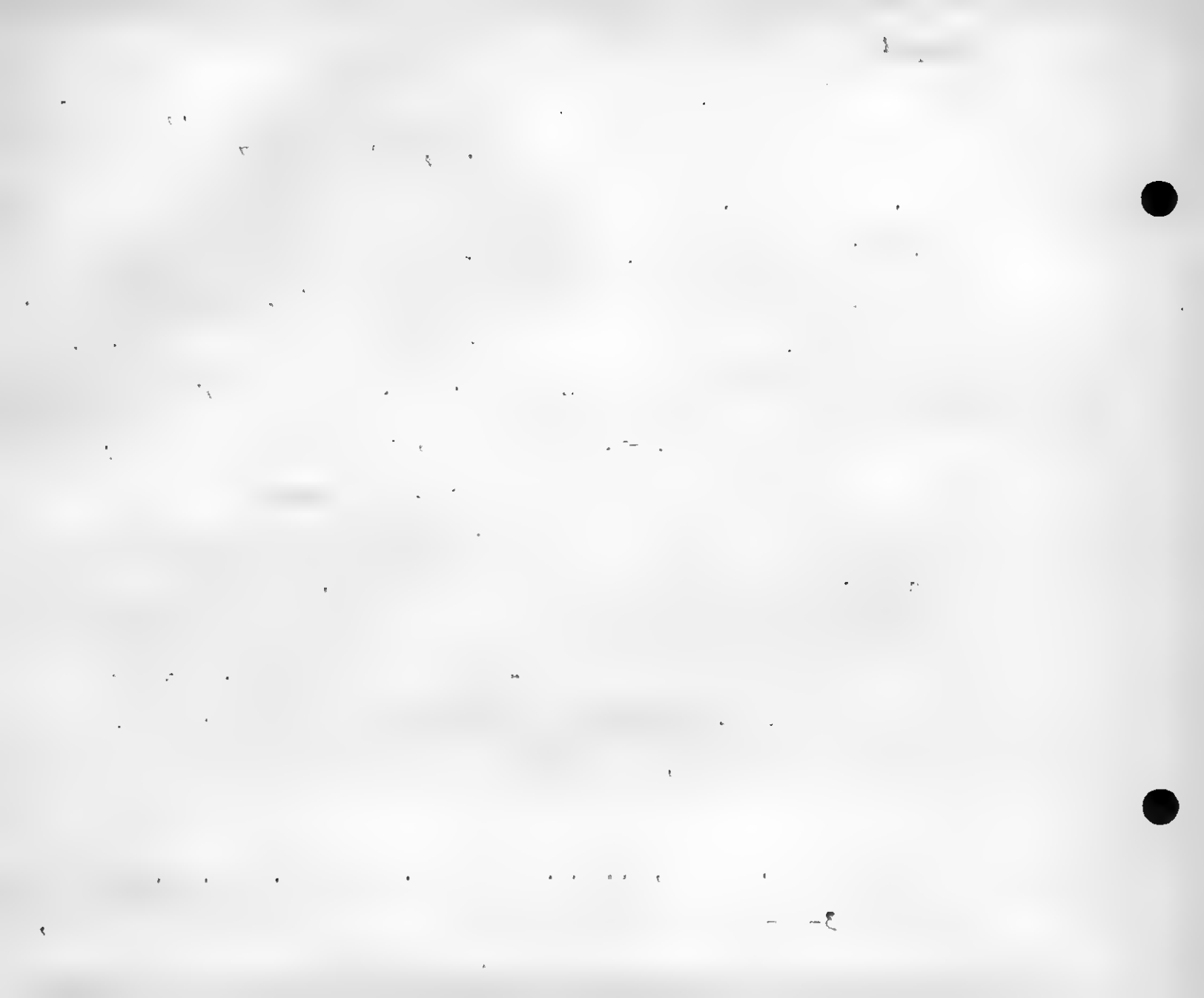
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health, prior to burial, cremation, or removal, and to be kept on file for 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03461			CERTIFICATE OF DEATH						03455				
1. DECEASED-NAME (Type or print) First Middle Last <div>Lizzetta Cecilia Ermer</div>			2a. DATE OF DEATH Month Day Year <div>March 17, 1969</div>			2b. HOUR <div>6:30 AM</div>							
3. SEX <div>Female</div>		4 RACE <div>White</div>		5. DATE OF BIRTH <div>Dec. 29, 1891</div>		6 AGE (in years last birthday) <div>77 YRS.</div>		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <div>Md.</div>		7b. CITIZEN OF WHAT COUNTRY? <div>U. S. A.</div>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <div>Baltimore Md</div>							
10. CITY OR TOWN OF DEATH <div>Catonsville</div>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <div>Summit Nursing Home</div>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <div>Housewife</div>		12b KIND OF BUSINESS OR INDUSTRY <div>At Home</div>					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <div>Md.</div>		13c CITY OR TOWN <div>Baltimore</div>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <div>1719 Forest Park Ave.</div>							
14 FATHER'S NAME First Middle Last <div>William P. Muth</div>				15. MOTHER'S MAIDEN NAME First Middle Last <div>Hannah C. Wallace</div>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <div>No</div>		16b SOCIAL SECURITY NO <div>215-32-8586</div>		17 INFORMANT Address: <div>Patricia Metzbower 2207 Krone Court</div>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <div>Cerebro-vascular accident, right hemiplegia</div> DUE TO, OR AS A CONSEQUENCE OF (b) <div>Arteriosclerotic cardiovascular disease</div> DUE TO, OR AS A CONSEQUENCE OF (c) <div>Diabetes mellitus with Uremia</div>													
										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <div>4 months</div>			
										<div>10 years</div>			
										<div>15 years</div>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <div>De'ducbitous ulcers over the right leg and sacral area.</div>													
MEDICAL CERTIFICATION	19a DATE OF OPERATION <div>XXXXXXX</div>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <div>XXXXXXXXXXXXXXXXXXXXXX</div>				20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? XXXXXXXXXXXXXXXX				
	21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year <div>P.M. 19</div>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) <div>XX</div>								
	21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) <div>XXXXXXXXXXXXXXXXXXXX</div>		21f LOCATION Street or R.F.D. No. City or Town County State <div>XX</div>								
	22a. I certify that (I) (as physician) attended the deceased from _____, 19_____, to _____, 19_____, that (I) personally saw the deceased alive on _____, 19_____, and that in (my) professional opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do not) view the body after death.												
	22b SIGNATURE <div>Millard T. Traband Jr</div>				Degree <div>M.D.</div>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <div>Millard T. Traband, Jr. M.D.</div>				22e. ADDRESS <div>1811 N.Rolling Rd. Balt. Md. 21207</div>									
23a BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		23b. DATE <div>3-20-1969</div>		23c. NAME OF CEMETERY OR CREMATORY <div>Lorraine Park</div>				23d. LOCATION (City or town) <div>Woodlawn</div>		(County) <div>Md,</div>		(State)	
24. FUNERAL DIRECTOR <div>G.Howard Strong 3207 W. North Ave.</div>				ADDRESS		25a. REC'D BY REGISTRAR <div>MAR 19 1969</div>		25b. REGISTRARS SIGNATURE <div>[Signature]</div>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
George S. Euler						3/20/69			6:30 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
Male		White		9/12/04		64 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Balto			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Catonsville			526 Charing Cross Road						
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md			Balto		Catonsville				526 Charing Cross Road
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Harry B. Euler				Marie Edell					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No				Mrs. George S. Euler		526 Charing Cross Rd			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>									1 day
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Atherosclerosis</u>									10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-17-1969</u> to <u>3-20-1969</u> , that (I) (we) last saw the deceased alive on <u>3-19-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b SIGNATURE <u>Wilmer K. Gallagher, Sr</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>3-21-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Dr. Wilmer K. Gallagher, Sr</u>						22e ADDRESS <u>6209 Frederick Road</u>			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		3/24/69		Parkwood Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave. 21229</u> ADDRESS						25a REC'D BY REG. STAFF <u>MAR 24 1969</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

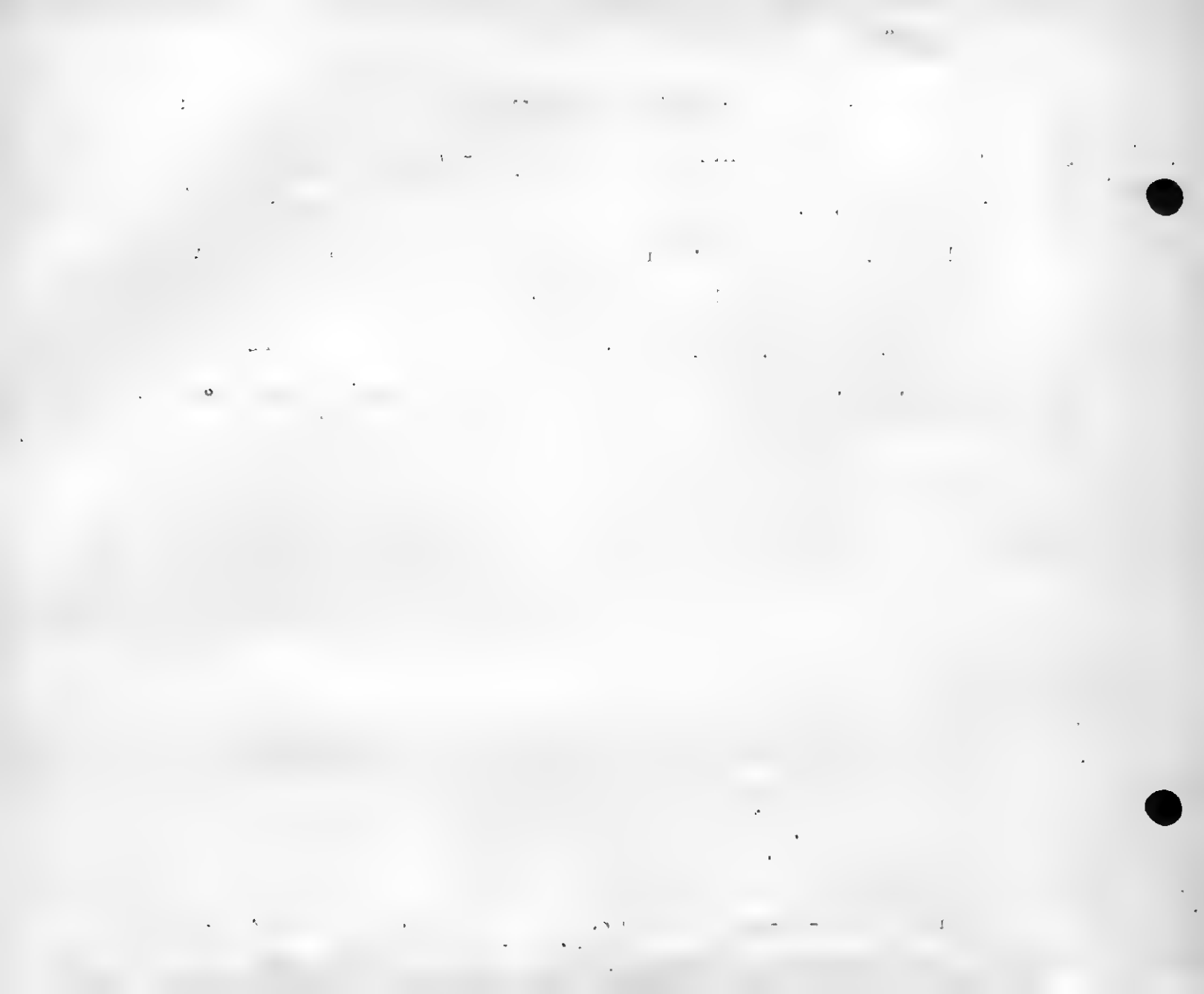


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VR A15
30M REV

03463		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03457	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) James Franklin Everitts			2a. DATE OF DEATH Month March Day 6 Year 69			2b. HOUR 7 ^{AM}	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-27-1914		6. AGE (In years last birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Martinsburg, W. Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6909 Digby Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrical Supervisor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 6909 Digby Road		14. FATHER'S NAME First Harry J. Middle Everitts Last Tucker		15. MOTHER'S MAIDEN NAME First Tucker Middle Everitts Last Beatrice		16. SOCIAL SECURITY NO WW 11 Navy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) Yes WW 11 Navy		16b. SOCIAL SECURITY NO WW 11 Navy		17. INFORMANT Beatrice Everitts-6909 Digby Road		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 68 , to March , 19 69 , that (I) (we) last saw the deceased alive on March 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph B Gross		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) Joseph B Gross		22e. ADDRESS 6911 Park Heights Rd Baltimore	
23a. BURL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-10-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR William P. Bennett Home Life Hgts Woe		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



03464

Item 8 Film 410 3/17/69 kk

CERTIFICATE OF DEATH

03458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1211 Fairfield Road</u>		d. STREET ADDRESS <u>1211 Fairfield Road</u>	
3. NAME OF DECEASED (Type or print) <u>Naisy</u> First <u>B.</u> Middle <u>Fair</u> Last		4. DATE OF DEATH <u>March</u> Month <u>4,</u> Day <u>19</u> Year <u>69</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1877</u> 1875 <u>95</u> (In years last birthday) yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs
11. BIRTHPLACE (County & State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Caleb W. Annacost</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-20-0260</u>	
17. INFORMANT <u>Mr. Donald T.A. Fair</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4104 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1967</u> , to <u>March 4, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Feb 28 1969</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. Allan Jones</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/4/69</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 7, 69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beckeyville Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co. Md.</u>
24. FUNERAL DIRECTOR <u>Tipton-Eline Funeral Home</u>		ADDRESS <u>Hampstead, Md.</u>	25a. REC'D BY REGISTRAR DATE <u>MAR 6 1969</u>
		25b. REGISTRAR'S SIGNATURE <u>William Jones</u>	

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03465

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03459

1. DECEASED-NAME (Type or print)		First Fallon,	Middle	Last Sarah	2a. DATE OF DEATH March Month 15 Day 1969 Year		2b. HOUR 12:00				
3 SEX F		4. RACE W		5. DATE OF BIRTH 6/15/30		6. AGE (In years) 38 YRS		7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS. DAYS	9. UNDER 24 HRS. HOURS	10. UNDER 24 HRS. M. N.
7a. BIRTHPLACE (State or foreign country) Westminister		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 212 W. Chesapeake Ave.			
14. FATHER'S NAME First William		Middle Callaghan		Last		15. MOTHER'S MAIDEN NAME First Anna		Middle Sheets		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-52-2488-J1		17. INFORMANT Stella Maris Hospice, Towson, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Arteriosclerosis Chronic and gangrene of left foot of one weeks duration. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 1968, to March 1969, that (I) (we) last saw the deceased alive on March 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Lee Robbins, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/15/69					
22d. PHYSICIAN'S NAME (Type) E. Lee Robbins, M.D.		22e. ADDRESS Mockingbird Lane									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-18-1969		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery, Govans		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE R. J. [Signature]					



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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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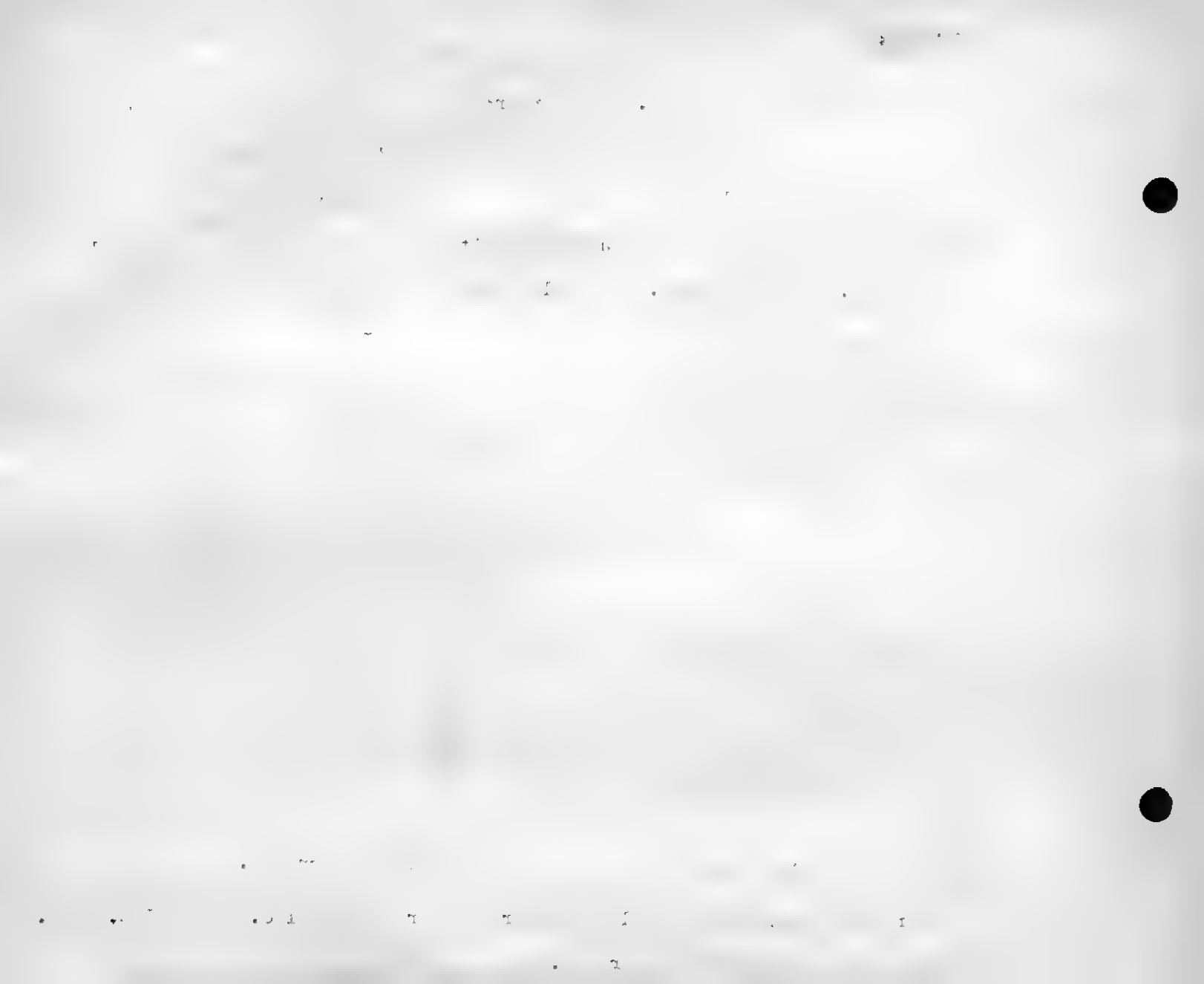
03466

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03460

1. DECEASED-NAME (Type or print) Mary			First Middle Last K. Ferrare			2a. DATE OF DEATH Month Day Year 3 20 1969			2b. HOUR M		
3 SEX Female			4. RACE White			5. DATE OF BIRTH August 13, 1899			6 AGE (In years last bthday) 69 YRS.		
7a. BIRTHPLACE (State or foreign country) Poland			7b. CITIZEN OF WHAT COUNTRY? Poland			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY Y/N <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e. STREET AND NUMBER 6115 The Alameda			14. FATHER'S NAME First Middle Last John			15. MOTHER'S MAIDEN NAME First Middle Last Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO 216 12 2178A			17. INFORMANT Address CLEMENTINE FERRARE 6115 The Alameda					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Venereal accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension (one line)</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1949</u> , to <u>3/20 1969</u> , that (I) (we) last saw the deceased alive on <u>3/28 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Conrad Richter</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>3/24/69</u>		
22d. PHYSICIAN'S NAME (Type) Conrad Richter						22e. ADDRESS 3128 Harford Rd.					
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE 3/24/1969			23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION (City or Town) (County) (State) Balto. Balto. Md.		
24. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.						25a. REC'D BY REGISTRAR DATE MAR 28 1969			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03467

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03461

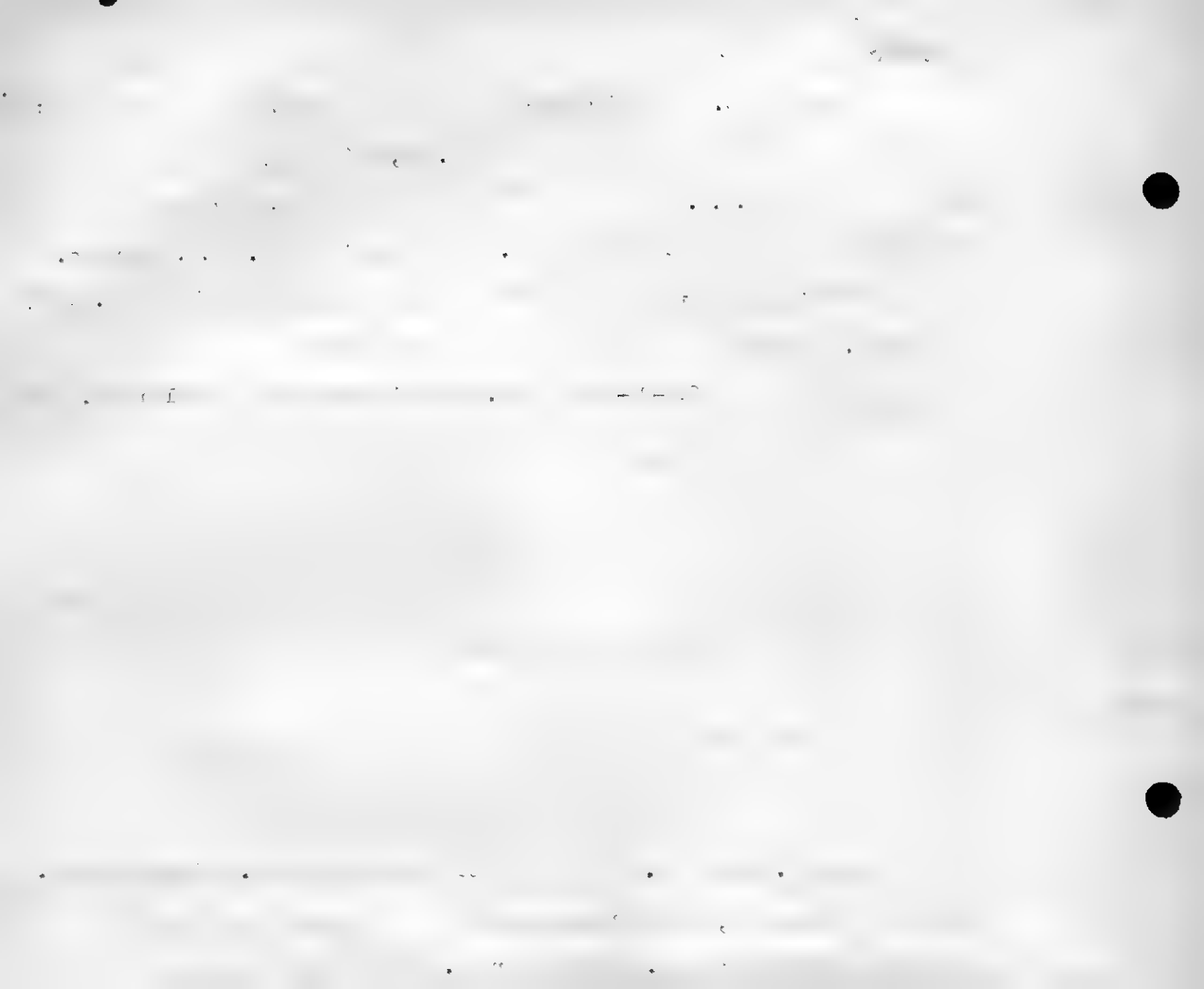
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Joseph		P.	Fiddes		Month Day Year March 9 69		9.20PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		January 7, 1922		47 YRS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Baltimore, Md		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph Hospital		Stillman - Calvert Distilling Co.				
13a. USUAL RESIDENCE (Where deceased lived if not in hospital on date of admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY LIMITS?		13e. STREET AND NUMBER
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2915 Fait Ave., -21224
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME						
First Middle Last Joseph R. Fiddes		First Middle Last Helen H. Pilert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT (Wife)				
Yes <input checked="" type="checkbox"/> (If yes give war dates of service) WWII		215-16-0513		Mrs. Rita M. Fiddes, 2915 Fait Ave. Address Balto. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal hemorrhage</u> <u>571.8</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>multifocal erosions of</u> <u>esophageal varices due to portal cirrhosis.</u> (c) <u>esophageal varices due to portal cirrhosis.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <u>2/15/ 1969</u> to <u>3/9/ 1969</u> , that (A) (we) last saw the deceased alive on <u>3/9/ 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Christina Feliciano, M.D.						March 10, 1969		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Christina Feliciano, M.D.		7620 York Rd., Towson Md., 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3/13/69		Balto. National Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John J. Duda, 2829 Hudson St. Balto. Md.				MAR 12 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS
45M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03468						03462					
DECEASED NAME (Type or print)						2a. DATE OF DEATH					
First Middle Last Ralph O. Fischbeck						Month Day Year March 9 69					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 26, 1913		6. AGE (in years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2b. HOUR 11:20 PM	
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 2132 Southland Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chemical Eng. W.R. Grace Co.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2132 Southland Ave. 21207			
14. FATHER'S NAME First Middle Last Ralph W. Fischbeck				15. MOTHER'S MAIDEN NAME First Middle Last Helen Osler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 319-01-9642		17. INFORMANT Address Mrs. Lula Fischbeck 2132 Southland Rd. 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Prostate 185 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 37 months											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Feb , 1965, to March 9, 1969 , that (I) (we) last saw the deceased alive on March 9, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David I. Miller		DEGREE MD.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) David I. Miller MD.		22e. ADDRESS 9115 Reisterstown Rd. Owings Mills Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 12, 69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Woodlawn Maryland					
24. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Rd. Randallstown Md.		25a. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE [Signature]					



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VR A15
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

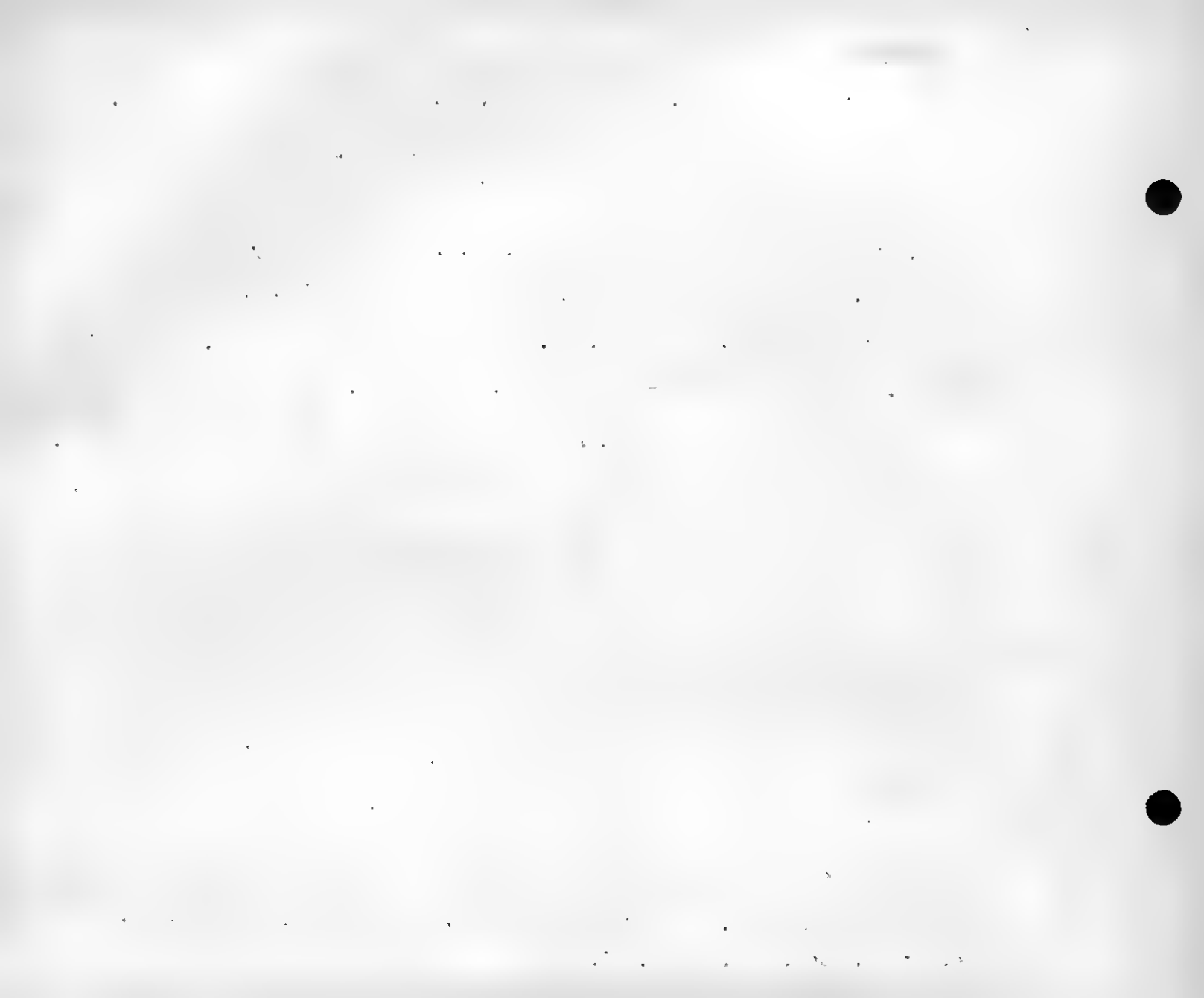
03469

CERTIFICATE OF DEATH

03463

1 DECEASED NAME (Type or print) WILLIAM		First H.	Middle	Last FISHER, JR.	2a. DATE OF DEATH March Month 14 , Day 1969		2b. HOUR 11:00 P M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH July 18, 1909.		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Carney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2918 Chenoak Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pipe Fitter		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2918 Chenoak Avenue
14. FATHER'S NAME First William		Middle H.	Last Fisher, Sr.		15. MOTHER'S MAIDEN NAME First Rose		Middle M.	Last Diggins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unk. (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 216-05-7590		17 INFORMANT Mrs. Gertrude B. Fisher		Address (Same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minute year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from January, 1963 , to 3-14, 1969 , that (I) (we) last saw the deceased alive on 3/12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/15/69		
22d. PHYSICIAN'S NAME (Type) MARION FRIEDMAN, MD				22e. ADDRESS 5211 HARFORD ROAD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/69.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211				25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4-5-69
30M REV 7-69

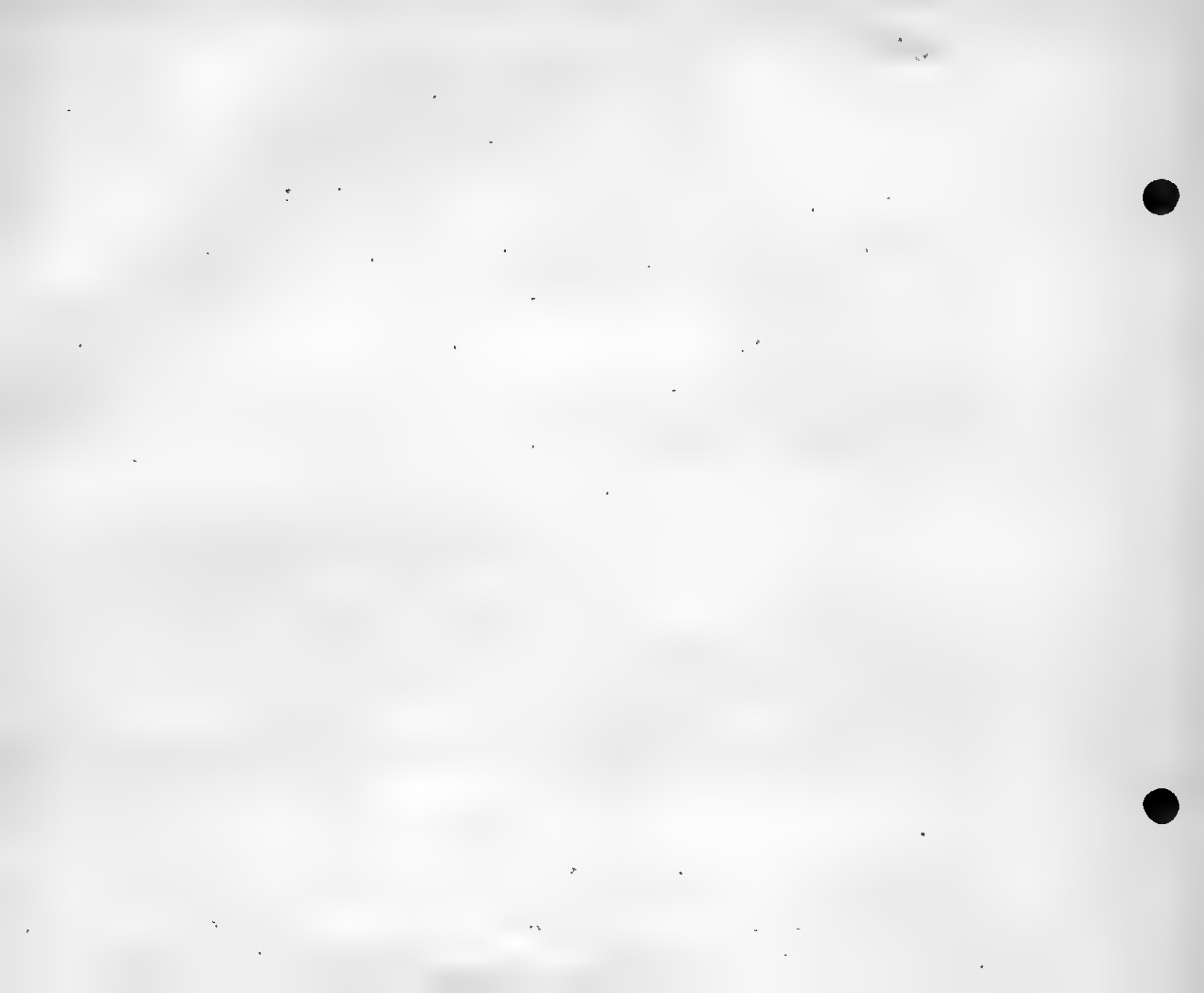
03470

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03464

1. DECEASED NAME (Type or print) <i>Harrison Franklin Fletcher Sr</i>		2a. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>69</i>		2b. HOUR <i>6:45 AM</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>3-8-1896</i>	6. AGE (In years lost birthday) <i>73</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Phil. Penn.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		
10. CITY OR TOWN OF DEATH <i>Pikesville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4108 Lowell Drive</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Insurance Agent</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>INS.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balt.</i>	13c. CITY OR TOWN <i>Pikesville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>4108 Lowell Drive</i>	
14. FATHER'S NAME First <i>Daniel</i> Middle <i>Y.</i> Last <i>Fletcher</i>	15. MOTHER'S MAIDEN NAME First <i>Virginia</i> Middle <i></i> Last <i>Mohr</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>yes</i>	16b. SOCIAL SECURITY NO. <i>12-03-4506</i>	17. INFORMANT <i>Mrs. Maria Fletcher</i>		Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aneurysm, abdominal aorta, rupture</i> <i>441</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVP</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>68</i> , to <i>18 March</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>16 March</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Charles H. Williams</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>3-18-69</i>
22d. PHYSICIAN'S NAME (Type) <i>Charles H. Williams, M.D.</i>				22e. ADDRESS <i>Pikesville, 21208, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3-21-1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		23d. LOCATION (City or Town) <i>Woodlawn</i>	(County) (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>G. Howard Strong 3207 W. North Ave.,</i>			25a. REC'D BY REGISTRAR <i>MAR 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115
30M REV 1-68

03471		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03465					
Item 23 Film 4/11 4/2/69 kk		CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First Alice		Middle Anastasia	Last Fleury		2a. DATE OF DEATH Month 3		Day 23	Year 69	2b. HOUR 8:30 A M
3 SEX Female		4. RACE Cau.		5. DATE OF BIRTH 6-11-1902		6. AGE (in years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Balto. Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Bradshaw		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bradshaw, Maryland		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. Co.					
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Bradshaw		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Bradshaw, Md 21021			
14 FATHER'S NAME First Stephen		Middle F.		Last Muller		15. MOTHER'S MAIDEN NAME First Blanche		Middle L.		Last Bradley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-09-5315		17 INFORMANT Address Dr. Mark Muller Upper Falls, Md. 21156							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 24 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Arteriosclerosis 4 yrs (c) Parkinson's Disease 4 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 1968, to 3/23, 1969, that (I) (we) last saw the deceased alive on 3/23 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen Muller MD		22c. DATE SIGNED 3/23/69		22d. PHYSICIAN'S NAME (Type) DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City or Town) (County) (State) Bradshaw Balto. Md.					
24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd. 21236		25a. REC'D BY REGISTRAR DATE MAR 27 1969		25b. REGISTRAR'S SIGNATURE J. J. J. J.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
45M 1X69

MEDICAL CERTIFICATION

MIDDLE											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b. HOUR	
Naomi		A.		Ford		March		Month 15 Day 1969		8 05 A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white		Sept. 1, 1897		71 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U. S.				Baltimore					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Catonsville		SPRING GROVE STATE HOSP.		housewife							
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.				Balto.				611 Chapelgate Lane			
4. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
George W. Seaman								Cora			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
				217-14-1704		Records: SPRING GROVE STATE HOSPITAL					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary thrombosis and infarcts										24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral bronchopneumonia										3-4 days	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1966, to March 15, 1969, that (I) (we) saw the deceased alive on March 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED					
Demetrios E. Kepas M.D.						3. 15. 69					
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS									
Demetrios E. Kepas M.D.		SPRING GROVE STATE HOSPITAL		Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3/18/69		Cedar Hill Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Witzke		4101 Edmondson Ave., 21229		MAR 18 1969		J. J. J. J.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT 5 (4)
30M REV 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03473					03467				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
EDWARD FRANKLY SR.					3 Month 1 Day 69 Year			9 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
M		W		8-2-92		26 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE COUNTY Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		BALTIMORE CO. GEN. HOSP.		Ret. Caretaker Balto. City					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
BALTIMORE		BALTO.		BALTIMORE				21 Milgate	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					
JOHN NMI		MARGARET BOVLON		NO					
16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
216-09-2758		Mrs. Theresa Franey 21 Milgate		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized carcinoma of the					
				1941 DUE TO, OR AS A CONSEQUENCE OF					
				Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF					
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-20-69 to 3-1-1969, that (I) (we) last saw the deceased alive on 3-1-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
George C. Pavek, M.D.		3-1-69		22e. ADDRESS					
				BALTO. CO. GEN. HOSP.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR	
Burial		March 4, 69		Woodlawn Cemetery		Woodlawn Maryland		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE			
Loring Byers 8728 Liberty Road Randallstown.		MAR 4 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03474

CERTIFICATE OF DEATH

03468

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b. HOUR 10 ⁵⁰ P. M.		
Virginia				Franklin	March 16, 1969				
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Female	White		April 19, 1907		61 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U S A				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		Notchcliff Rd.		Homemaker		At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Baltimore				1548 S. Hanover St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
William E. Worthington					Louise Hopkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No						Herbert F. Franklin		1548 S. Hanover St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary site unknown - thought to be lung</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
22a. I certify that (1) (this hospital) attended the deceased from <u>3/13</u> , 1966, to <u>3/16</u> , 1969, that (1) (we) last saw the deceased alive on <u>3/16</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		W. M. Smith M.D.		22c. DATE SIGNED		3/18/69			
22d. PHYSICIAN'S NAME (Type)		W. M. Smith		22e. ADDRESS		6305 THE ACACIA			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Mar. 19, 1969		Cedar Hill		Brooklyn, A. A. Co. Md.			
24. FUNERAL DIRECTOR		Mc Cully		130 E. Fort Ave		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						MAR 19 1969		J. L. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03475

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03469

1. DECEASED NAME (Type or print) HERBERT W. FREEMAN		2a. DATE OF DEATH 3 Month 21 Day 69 Year		2b. HOUR 9:30 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH AUG. 11, 1901	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTO.	
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 25 SOMERSET Rd	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY BALTO.	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 25 SOMERSET Rd 21228
14. FATHER'S NAME First MARION Middle FREEMAN Last M=NAIR	15. MOTHER'S MAIDEN NAME First M=NAIR Middle M=NAIR Last M=NAIR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 215225331	17. INFORMANT Rose K. FREEMAN Address 25 SOMERSET Rd #28		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, acute DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 12 yrs.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (the hospital) attended the deceased from AUG. 11, 1961 , to MARCH 21, 1969 , that (I) (we) last saw the deceased alive on FEB 21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Leo J. Gaver, M.D.		22c. DATE SIGNED MARCH 23, 1969		22d. PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY Louisa PK. Cem
23d. LOCATION (City or Town) (County) (State) BALTO. Md.		23e. REC'D BY REGISTRAR M.F. 26 1969		
24. FUNERAL DIRECTOR E.S. MacNabb		25b. REGISTRAR'S SIGNATURE John J. Judge		

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03476

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03470

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instruction; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>1 YR</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		d. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>924 GARDEN DRIVE</u>				d. STREET ADDRESS <u>924 GARDEN DRIVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Louis Friskey</u>				4. DATE OF DEATH Month Day Year <u>MARCH 10, 1969</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 2, 1913</u>	
9. AGE (in years last birthday) <u>55 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIME KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOBLE L. FRISKEY</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE P. CASSELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>214-21-9801</u>		17. INFORMANT Address <u>DOROTHY LANE 5011 FREDERICK AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> <u>1124</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>6808 MONROETON RD, DUNDALK MD 21222</u>							
ACTUAL SIGNATURE <u>MELVIN B. DAVIS</u>		M.D. <u>H.D.</u>		DATE SIGNED <u>3/10/69</u>			
EXAMINER'S NAME (Type) <u>MELVIN B. DAVIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-13-69</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. COUNTY MD.</u>	
23. FUNERAL DIRECTOR <u>GEO. L. SCHWAB FUNERAL HOME</u> <u>Francis H. Yellow 2101 Frederick Ave.</u>				24a. REC'D BY REGISTRAR <u>MAI 12 1969</u>			
24b. REGISTRAR'S SIGNATURE <u>Shawley Judge</u>							

MEDICAL CERTIFICATION

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03477

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03471

1. DECEASED-NAME (Type or print) JAMES HERSCHEL GAINES			2a. DATE OF DEATH Month MARCH Day 20 , Year 1969			2b. HOJR 11:45P					
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH 10/25/16		6 AGE (In years last birthday) 52 YRS		7 UNDER YEAR MONTHS 11 DAYS 11 HOURS 45 MIN			
7a BIRTHPLACE (State or foreign country) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			12b. KIND OF BUSINESS OR INDUSTRY MARITIME		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY MARITIME		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 1409 NORTH CAROLINE STREET			14. FATHER'S NAME First JAMES Middle - Last GAINES			15. MOTHER'S MAIDEN NAME First ELVIRA Middle - Last GILMORE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown YES (If yes give year or dates of service) WWII			16b. SOCIAL SECURITY NO. 215 12 7025			17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY 472X DUE TO, OR AS A CONSEQUENCE OF, OBSTRUCTIVE AND BULBOUS EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASTHMATIC BRONCHITIS (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSION OF LESSER CIRCULATION (COR PULMONALE)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (a) (this hospital) attended the deceased from MAR 13 , 19 69 , to MAR 20 , 19 69 , that (b) (we) last saw the deceased alive on MAR 20 , 19 69 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (not) view the body after death											
22b. SIGNATURE <i>R. D. Miro</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/21/69			
22d. PHYSICIAN'S NAME (Type) R. D. MIRO, M.D.						22e. ADDRESS VAH, FT. HOWARD, MD.					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE 3-25-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR <i>Elroy O. Wilson</i> ELROY O. WILSON FUNERAL HOME						ADDRESS BALTO, MD.		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03478

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03472

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Charles Frederick Gais						March 29 1969			7 P.M.		
3 SEX	4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		F UNDER YEAR		IF UNDER 24 MRS	
Male	White		July 28, 1902			66 YRS.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Baltimore		U.S.A.				Baltimore					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Baltd. Med. Center			Maintenance			Dausch-Haurde		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3656 Dudley Ave.			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John					Gais	Anna					Schrack
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
no			212-07-9523			Thresa Macheck, sister, Box 18			Hampstead, Md. 21074		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u>											
1538 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia, lung abscesses & pyelonephritis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Carcinoma of colon</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1969, to Mar. 29, 1969, that (I) (we) last saw the deceased alive on Mar. 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Adams, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Mar. 30, 1969			
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22e. ADDRESS 6701 N. Charles St., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			4/2/69		Holy Redeemer Cem.		Baltimore, Md.				
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane						25a. RECD BY REGISTRAR APR 2 1969 DATE		25b. REGISTRAR'S SIGNATURE			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF BIRTH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Parkton		c. LENGTH OF STAY IN 1b 29Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ANNA		4. DATE OF DEATH Month March Day 30 Year 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1878
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Urey	
14. MOTHER'S MAIDEN NAME Eliza Minker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 192-32-2886		17. INFORMANT Address Mrs. H.E. Wilhelm, Parkton, Md. 21120	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO 4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general infarction of old age DUE TO (c) advanced arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1968 , to June 23, 1969 , that (I) (we) last saw the deceased alive on March 25, 1969 , and that death occurred at 2:30 PM from causes and on the date stated above			
22a. SIGNATURE Norman H. Gemmill		22b. DATE SIGNED 3/31/69	
22c. PHYSICIAN'S NAME (Type) Norman H. Gemmill M.D.		22d. ADDRESS Stewartstown, Penna. 17363	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 2, 1969	23c. NAME OF CEMETERY OR CREMATORY McKendree Cemetery	23d. LOCATION (City or Town) (County) (State) Airville, York Co., Penna.
24. FLUNERAL DIRECTOR Samuel A. Osburn		25a. RECEIVED BY REGISTRAR DATE APR 3 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03480

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03474

1 DECEASED NAME (Type or Print) WILLIAM DALLAS GERBER		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MAR 27 1969		2b HOUR 2 A M
3 SEX M	4 RACE W	5 DATE OF BIRTH 4-24-24	6 AGE (In years last birthday) 44 YRS	7c IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10 CITY OR TOWN OF DEATH Timonium Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 301 Deep Dale Dr		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Asphalt Business
13a USUAL RESIDENCE (Where deceased lived, if in institution, give address) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Timonium
14 FATHER'S NAME First Middle Last William D. Gerber Sr.		15 MOTHER'S MAIDEN NAME First Middle Last Minna Marie		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. 219-11-4994		17 INFORMANT Patricia C. Gerber
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS AND OBESITY				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 3-27-69
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Timonium Md.
23a BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b DATE 3-29-69	23c NAME OF CEMETERY OR CREMATORY Landon Park	23d LOCATION (City or town) (County) (State) Frederick Rd. Baltimore Md.	25a REC'D BY REGISTRAR Charles Judge
24 FUNERAL DIRECTOR Supple Bros.		ADDRESS 7110 Belair Rd.		DATE MAR 28 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1

03481

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03475

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
EDWARD			NMN	GETZ	3 Month 9 Day 69 Year		2:40 a		
3. SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	CAUCASIAN		1-7-1901		68 YRS.		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		GREAT BALT MED CENT							
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TS?		13e. STREET AND NUMBER	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6501 Woodring Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Casper		Getz		Margaret Boehn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
		14-01-8416		Mrs. Mary Getz, 3501 Woodring Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATERIOSCLEROTIC CARDIOVASCULAE DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF <u>with AORTIC STENOSIS</u> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				3-8 69, to 3-9-1969, that (we) last saw the deceased alive on 3-9-1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED							
Charles C. Brown, M.D.		3-9-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
CHARLES C. BROWN, M.D.		6701 NORTH CHARLES ST							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 1, 1969		Parkwood Cemetery		Parkville, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ulrich Funeral Home		4 10 Belair Road.		MAK 13 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

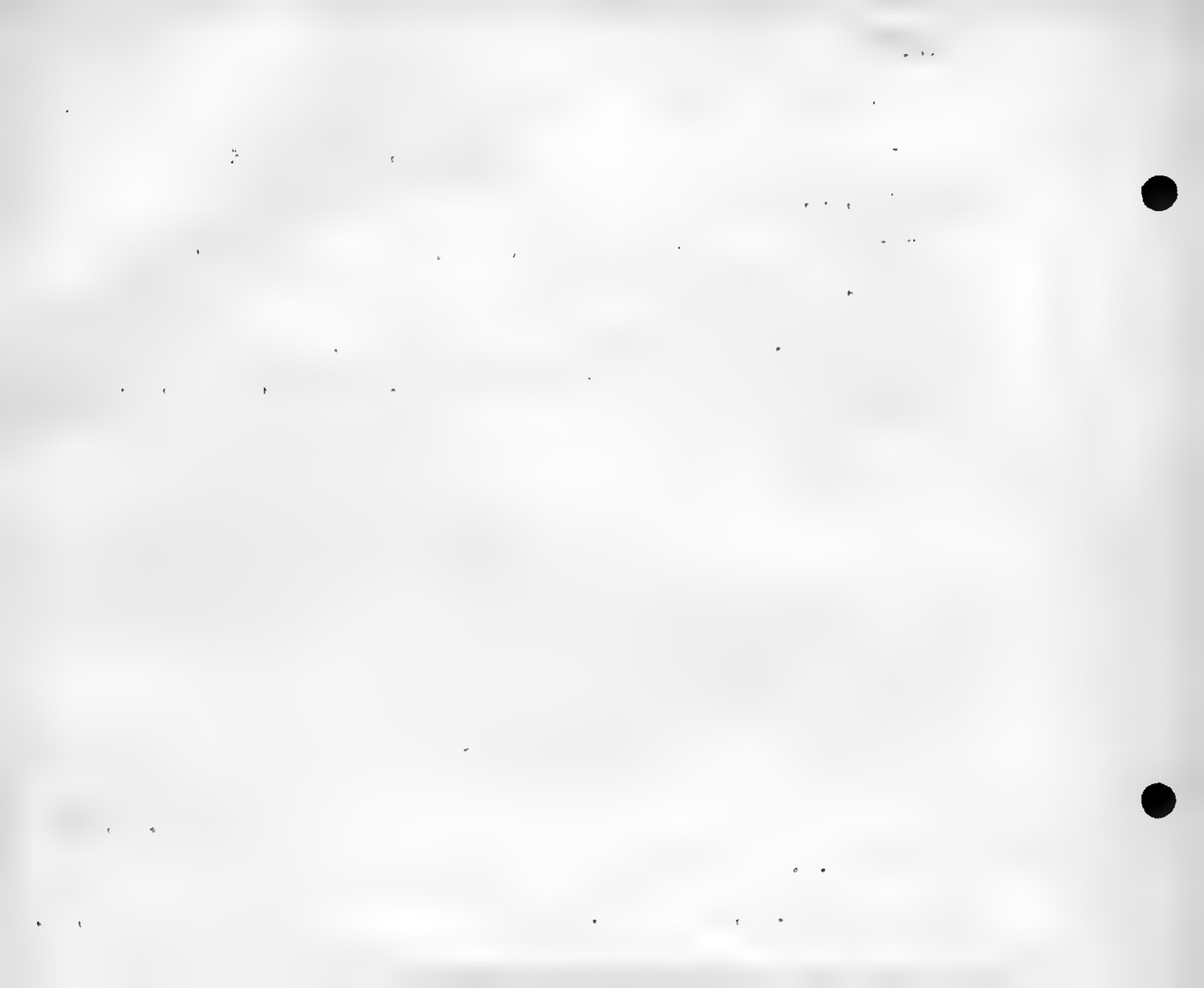
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03482 CERTIFICATE OF DEATH 03476									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JULIA ROSE GETZEL						3 Month 8 Day 69 Year			8:55 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Female		Caucasian		06-09-21		47 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Baltimore		U.S.A.				Baltimore		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Cent.		Housewife		at home			
13a USUAL RESIDENCE (Where deceased lived admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, I.M.T.S?		13e STREET AND NUMBER	
Md.		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21206 4600 Eugene Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Joseph Dobropolski			unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
			215-18-2776			Lawrence Getzel, husband, above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure with									
DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusions-diabetes mellitus									
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Chronic renal failure with renal tubal acidosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (X) (this hospital) attended the deceased from 3/6, 19 69, to 3/8, 1969, that (X) (we) lost saw the deceased alive on 3/8, 19 69, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE				22c DATE SIGNED					
Dr. George Pikler				3-9-69					
22d PHYSICIAN'S NAME (Type)				22e ADDRESS					
Dr. George Pikler				6701 N. Charles St.				21204	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		3/12/69		Parkwood Cemetery		Baltimore, Md.			
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.				DA MAR 13 1969		Charles Judge			
3331 Brehms Lane									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03483 CERTIFICATE OF DEATH 03477									
1 DECEASED-NAME (Type or print) MAHALA			First Middle Last			2a DATE OF DEATH			2b HOUR
			CAU			June 24, 1893			6:35 PM
3 SEX FEMALE			4 RACE			5 DATE OF BIRTH			6 AGE (last birthday) 75 YRS.
7a BIRTHPLACE (State or foreign country) Pylesville, Md.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE
10 CITY OR TOWN OF DEATH BALTIMORE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MED. CEN			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md.			13b COUNTY Harford			13c CITY OR TOWN Street			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME John S. McAllister			First Middle Last			15. MOTHER'S MAIDEN NAME Laura L. Flaharty			First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-38-9157			17 INFORMANT Martin L. Glackin, Street, Md. 21154			Address
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL EDEMA WITH CEREBRAL INFARCTS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) BRANN TUMOR (GLIOBLASTOMA MULTI FORME)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/13 , 19 69 , to 3/15 , 19 69 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Mar. 16, 1969	
22d. PHYSICIAN'S NAME (Type) DR. R. BREITENECKER						22e. ADDRESS Greater Baltimore Medical Center			
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE Mar. 19, 1969			23c. NAME OF CEMETERY OR CREMATORY St. Mary's			23d. LOCATION (City or Town) (County) (State) Pylesville, Harford, Md.
24. FUNERAL DIRECTOR <i>[Signature]</i>						25a. REC'D BY REGISTRAR MAR 19 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03484

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03478

1 DECEASED NAME (Type or print)		First Middle Last GEORGE W. GLENDENNING		2a DATE OF DEATH March Month 15, Day 1969 Year		2b HOUR M					
3 SEX Male		4 RACE White		5. DATE OF BIRTH May 22, 1898		6. AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8-MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangri La Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Runner		12b KIND OF BUSINESS OR INDUSTRY Bank					
13a USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Pasadena		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 715 Pasadena Road		21122	
14 FATHER'S NAME First Middle Last Alfred Glendenning				15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Smith							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT Mrs. Viola A. Glendenning, 715 Pasadena Rd.		Address 21122					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4124 IMMEDIATE CAUSE (a) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1955, to 3/15, 1969, that (I) (we) last saw the deceased alive on 3/12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. John C. Pound				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 3325 Frederick Avenue, Balto., Md. 21229							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 3-19-1969		23c NAME OF CEMETERY OR CREMATORY Western Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				ADDRESS		25a RECEIVED BY REGISTRAR MAR 19 1969 DATE		25b REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03485										
03479										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First ANNIE		Middle M.		Last GOETZ		2a DATE OF DEATH Month 3 - Day 19 - Year 69	
3 SEX Female			4 RACE White			5 DATE OF BIRTH 11-8-1894			6 AGE (in years last birthday) 74 YRS	
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital			12a USLA. OCCUPATION (Kind of work done during most of working life, even if retired) homemaker			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Towson			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 814 Mockingbird Lane			13f ZIP CODE 21204			14 FATHER'S NAME First William Middle H. Last Flayhart			15. MOTHER'S MAIDEN NAME First Leah Middle Flayhart Last Flayhart	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO. 212-01-0061			17 INFORMANT Mr. Frank M. Goetz			Address Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiac-vascular disease 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____				
22a. I certify that (I) (this hospital) attended the deceased from 3-3- , 19 69 , to 3-19 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3-19- 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d not) view the body after death.										
22b SIGNATURE <i>Beatriz P. Dizon</i> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 3-19-69		
22d PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D.						22e ADDRESS 7620 York Road, Towson, Maryland 21204				
23a BURIAL, CREMATION, REMOVAL (Specify) burial			23b DATE 3/22/69		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d LOCATION (City or Town) (County) (State) Balto. Md.		23e REGISTRAR'S SIGNATURE <i>William J. Jones</i>	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home			ADDRESS 6500 York Rd. Balto.			25a REC'D BY REGISTRAR MAR 24 1969		25b REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

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03486

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03480

1. DECEASED NAME (Type or print) Charles W. Grant			2a. DATE OF DEATH Month 3 / Day 8 / Year 69			2b. HOUR 7:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12/9/83		6. AGE (In years last birthday) 85	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shady Nook Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) bank		12b. KIND OF BUSINESS OR INDUSTRY bank	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md		13b. CITY OR TOWN Balto		13c. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER 6148 Regent Park Road	
14. FATHER'S NAME Charles W. Grant				15. MOTHER'S MAIDEN NAME Virginia Lee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 215-10-2100		17. INFORMANT Mrs. William France, 6148 Regent Park Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) None						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month 12 Day 9 Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1969 to March 11, 1969 , that (I) (we) last saw the deceased alive on March 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard McKay M.D.				ATTENDING PHYSICIAN DEGREE <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> M.P.H. <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-69	
22d. PHYSICIAN'S NAME (Type) Dr. McKay				22e. ADDRESS 6014 Edmondson Avenue			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/12/69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave.,				25a. REC'D BY REGISTRAR MAR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

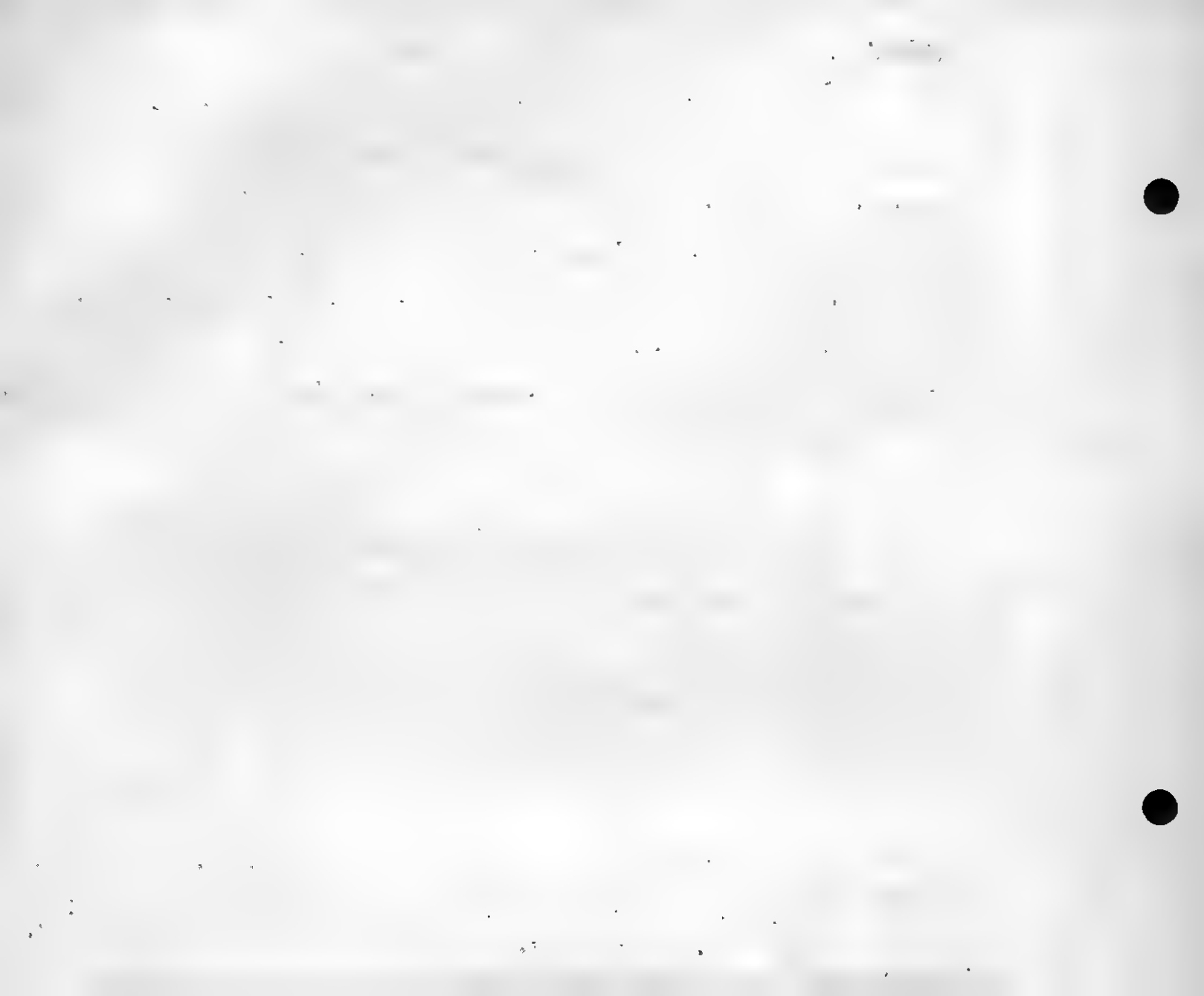
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03487

CERTIFICATE OF DEATH

03481

1. DECEASED-NAME (Type or print) First Middle Last WILLIAM THOMAS GRAY			2a. DATE OF DEATH Month Day Year March 16, 1969		2b. HOUR 6:15 P.M.
3 SEX Male	4. RACE White	5. DATE OF BIRTH December 12, 1888		6. AGE (In years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Balto., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Middle River	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ivy Hall Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Painter
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 3231 Fleet St. #21224.	
14. FATHER'S NAME First Middle Last Walter Gray			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 216-03-0864		17. INFORMANT Address Thomas I. Gray : 319 N. Robinson St. #21224.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE SESE M.D.				22c. DATE SIGNED 3/17/69	
22d. PHYSICIAN'S NAME (Type) SAMUEL STERN				22e. ADDRESS Ridge Rd., Balto. Co., Md. 21236.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	
23d. LOCATION (City or Town) (County) (State) 7401 German Hill Rd., Ba. Co.		23e. REG. BY REGISTRAR Charles S. Zeiler			
24. FUNERAL DIRECTOR Charles S. Zeiler		6224 Eastern Ave. Balto., 21224, Md.		25a. REG. BY REGISTRAR MAR 19 1969	
25b. REGISTRAR'S SIGNATURE Charles S. Zeiler		DATE			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03489

CERTIFICATE OF DEATH

03483

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 3 Day 12 Year 69		2b. HOUR 10:25	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Oct. 22, 1928		6 AGE (In years last birthday) 40 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood State Hospital		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1203 Briscoe St.,
14. FATHER'S NAME First Middle Last John -- GREENWOOD		15. MOTHER'S MAIDEN NAME First Middle Last Elsie -- FOREMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO -----		17 INFORMANT Address Rosewood Records, Owings Mills, Md. 21117				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia Bilateral</u> 486X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/4/69 - 3/12/69								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Inherited retardation - Microcephaly - idiot</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>22</u> , to <u>3/12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Esteban V. Diaz</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/13/69		
22a. PHYSICIAN'S NAME (Type) Esteban Diaz, M.D.				22b. ADDRESS Rosewood State Hospital				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 3/15/1969		23c. NAME OF CEMETERY OR CREMATORY Boswell M.C. Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.		
24. FUNERAL DIRECTOR <u>John J. Cowan, Inc.</u>				ADDRESS 901 Hopkins St. Baltimore		25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE <u>William J. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03490

CERTIFICATE OF DEATH

03484

1. DECEASED-NAME (Type or print) <u>Sarah Jane Grey</u>			2a. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1969</u>			2b. HOUR <u>9:15 PM</u>					
3. SEX <u>Female</u>		4. RACE <u>negro</u>		5. DATE OF BIRTH <u>6-7-25</u>		6. AGE (In years last birthday) <u>43</u> YRS		7. UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		8. UNDER 24 HRS. HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore County, Md.</u>					
10. CITY OR TOWN OF DEATH <u>Mount Wilson</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Mt. Wilson St. Hosp.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>House work</u>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MD.</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>CO.</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>127 Archer St. Bel Air, Md.</u>			
14. FATHER'S NAME First <u>Howard</u> Middle <u>Grey</u> Last <u>Grey</u>			15. MOTHER'S MAIDEN NAME First <u>Martha</u> Middle <u>Presbrey</u> Last <u>Presbrey</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <u>218-22 5940</u>			17. INFORMANT Address <u>Records, Mt. Wilson State Hospital</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> <u>518 X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive Airway Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchietasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> , 19 <u>69</u> , to <u>3-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W Newcomer</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>						22e. ADDRESS <u>Mount Wilson, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-15-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burkley Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Darlington Md</u>					
24. FUNERAL DIRECTOR <u>George W. Tittle, Bel Air Md</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



03491

CERTIFICATE OF DEATH

03485

1 DECEASED-NAME (Type or print) <i>Henry Frederick Grimm</i>			2a DATE OF DEATH <i>March 22, 1969</i>			2b. HOUR <i>M</i>		
3. SEX <i>Male</i>			4 RACE <i>White</i>			5 DATE OF BIRTH <i>11-29-84</i>		
7a BIRTHPLACE (State or foreign country) <i>N.Y.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			6 AGE (In years last birthday) <i>84</i> YRS.		
7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Balto.</i>					
10. CITY OR TOWN OF DEATH <i>Towson</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesterfield Manor</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Distribution Engineer Elec. Co.</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Balto</i>			13c CITY OR TOWN <i>Balto</i>		
14 FATHER'S NAME <i>Frederick</i>			15. MOTHER'S MAIDEN NAME <i>Unknown</i>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b SOCIAL SECURITY NO <i>212-05-5782</i>			17 INFORMANT <i>Henry O. Grimm, son, 3127 Chesterfield Av</i>		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Metastasis</i>								<i>6 wks</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Larynx</i>								<i>1 year</i>
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>March 19 1969</i> to <i>March 22 1969</i> , that (I) (we) last saw the deceased alive on <i>March 19 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death								
22b SIGNATURE <i>Charles J. Jones</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>3/21/69</i>		
22d PHYSICIAN'S NAME (Type)				22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>3/25/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc. 3331 Brehms Lane</i>				25a REC'D BY REGISTRAR <i>MAR 26 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03492

03486

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Ida G. Gross			2a. DATE OF DEATH Month Day Year March 24, 1969			2b. HOUR A M 1:30	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 10-6-1876		6. AGE (In years last birthday) 92 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) Holly Hill Manor Nursing Home 531 Stevenson Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dressmaker		12b. KIND OF BUSINESS OR INDUSTRY Dress	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Thomas Chenworth		15. MOTHER'S MAIDEN NAME First Middle Last Ellen Cook		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 220-07-9741A		17. INFORMANT Address Francis D. Gross 249 Stanmore Rd. 21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gangrene left leg due to thrombosis of femoral artery DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs. 4 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 19, 1959 , to Mar. 24, 1969 , that (I) (we) last saw the deceased alive on March 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lloyd E. Saylor M.D.				22c. DATE SIGNED March 25, 1969		22d. PHYSICIAN'S NAME (Type) Lloyd E. Saylor	
22e. ADDRESS 3902 Greenmount Avenue				22f. ADDRESS 3902 Greenmount Avenue			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-26-1969		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204				25a. REC'D BY REGISTRAR DATE MAR 26 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03493 CERTIFICATE OF DEATH 03487										
1 DECEASED-NAME (Type or print)			First Gertrude		Middle L.	Last Grothaus		2a. DATE OF DEATH Month 3 Day 4 Year 1969		2b. HOUR 10:30 A.M.
3 SEX Female		4 RACE White		5 DATE OF BIRTH 12/6/1881		6 AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md		
10 CITY OR TOWN OF DEATH Anneslie			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 520 Dunkirk Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Anneslie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 520 Dunkirk Rd.	
14. FATHER'S NAME First Peter Middle Flaherty Last			15. MOTHER'S MAIDEN NAME First Mary Middle Collins Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 215 48 1685 J1		17 INFORMANT D. Benton Grothaus			Address 520 Dunkirk Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 15 yrs. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 1959, to <u>Mar. 4</u> , 1969, that (I) (we) last saw the deceased alive on <u>Feb. 20</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Lloyd E. Saylor M.D.</u>				22c. DATE SIGNED Mar. 6, 1969				22d. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		
22e. ADDRESS 3902 Greenmount Avenue										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/7/1969		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City or Town) Baltimore		(County) Balto.		(State) Md.
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.				25a. REC'D BY REGISTRAR DATE MAR 11 1969		25b. REGISTRAR'S SIGNATURE <u>J. J. J. J.</u>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

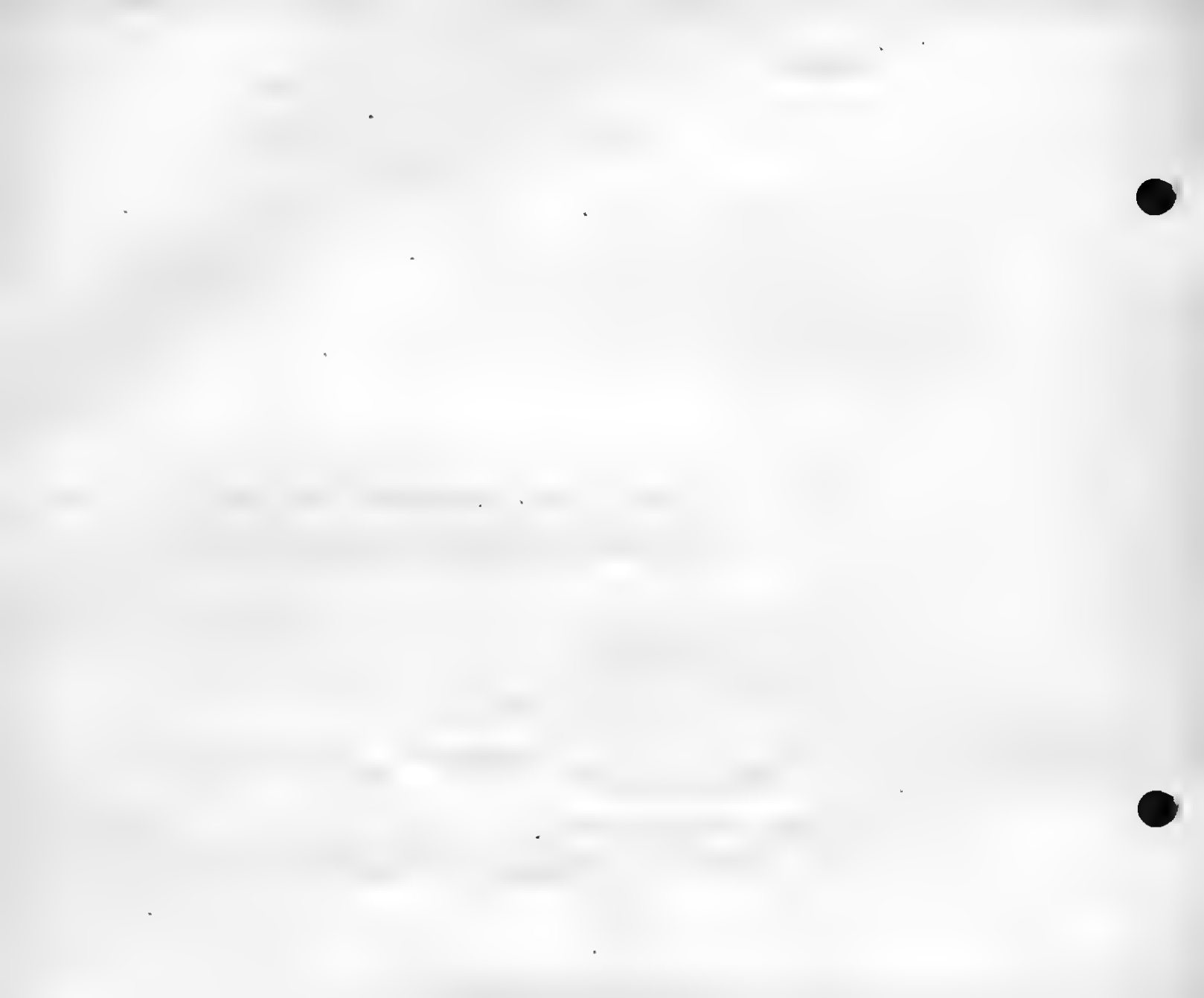
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03494

CERTIFICATE OF DEATH

03488

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rosedale c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rosedale d. STREET ADDRESS 1606 Rosedale Heights Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle GRUNER Last SR.		4. DATE OF DEATH Month March Day 20 Year 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Martin's	
11. BIRTHPLACE (County & State, or foreign country) Violet, La.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Gruner		14. MOTHER'S MAIDEN NAME Marie (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 216-09-4999		16. SOCIAL SECURITY NO. 216-09-4999	
17. INFORMANT Mary Robinson Gruner, wife, a above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular Disease DUE TO (b) 1 yr DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1969 , to March 20, 1969 , that (I) (we) last saw the deceased alive on March 20, 1969 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE M. Baumgardner		22b. DATE SIGNED 3/21/69	
22c. PHYSICIAN'S NAME (Type) E. M. Baumgardner		22d. ADDRESS Balto 21237	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/24/69	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR MAR 26 1969 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03495

CERTIFICATE OF DEATH

03489

1 DECEASED NAME (Type or print)			First	Middle	Lost	2a DATE OF DEATH Month Day Year			2b HOUR		
Edward			P		Gudaitis	March 9 1969			3 P M		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		if UNDER 1 YEAR MONTHS		if UNDER 24 HRS. HOURS MIN	
Male		White		Jan. 13, 1894		75 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore Md.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Baltimore			8648 Rock Oak Rd			Retired Factory Work					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Baltimore		Baltimore				8648 Rock Oak Rd		
14. FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First	Middle	Lost
Joseph					Gudaitis	Margaret					Baltrusaitis
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No			218-07-0341-A			Mrs Leona Julijona Gudaitis			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary & Systemic Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 15, 1962</u> , to <u>March 9, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Wm Conway M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>3/10/69</u>			
22d. PHYSICIAN'S NAME (Type) William M Conway M.D.						22e ADDRESS <u>8358 Loch Raven Blvd Balto, Md</u>					
23a BURIAL, CREMATION, REMOVA (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial		3/12/69		Holy Redeemer			Baltimore, Maryland				
24 FUNERAL DIRECTOR Leonard J Buck Inc. Baltimore, Maryland						25a REC'D BY REGISTRAR <u>MAR 10 1969</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03496

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03490

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Anna Middle M. Last Guldan			2a. DATE OF DEATH Month March Day 7 Year 1969			2b. HOUR M							
3 SEX Female		4 RACE White		5 DATE OF BIRTH June 16, 1916		6 AGE (In years last birthday) 52 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md							
10 CITY OR TOWN OF DEATH Dundalk			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1226 Hillshire Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1226 Hillshire Road				
14. FATHER'S NAME First Augustine Middle Last Tancibok			15. MOTHER'S MAIDEN NAME First Josephine Middle Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or unknown) No			16b. SOCIAL SECURITY NO 220-05-0321		17 INFORMANT (Husband) Mr. Joseph S. Guldan,			Address Dundalk, Md. 1226 Hillshire Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast bilat</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (if) (this hospital) attended the deceased from Jan 24, 1969, to Feb 7, 1969, that (if) (we) last saw the deceased alive on Feb 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Benigno R. Lazaro</u>						DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED March 7, 1969			
22d. PHYSICIAN'S NAME (Type) Benigno R. Lazaro						22e. ADDRESS 59 Dundalk, Ave. Dundalk, Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. REC'D BY REGISTRAR DATE MAR 11 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03497

CERTIFICATE OF DEATH

03491

1. DECEASED-NAME (Type or print) DAVID JOSEPH HAINES			2a. DATE OF DEATH Month MARCH Day 6 Year 1969			2b. HOUR 11:15 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH OCTOBER 18, 1897		6. AGE (in years last birthday) 71 YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HOSPITAL VETERANS ADMINISTRATION		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TIN CUTTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MARYLAND		13b. CITY OR TOWN BALTIMORE	13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 308 N ELLWOOD AVENUE		
14. FATHER'S NAME First DAVID Middle HENRY Last HAINES			15. MOTHER'S MAIDEN NAME First EMMA Middle _____ Last ADAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) YES WWI		16b. SOCIAL SECURITY NO 215 03 3769		17. INFORMANT Address CLINICAL RECORDS, VA HOSP, FORT HOWARD, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH, ADVANCED 151.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that XX (this hospital) attended the deceased from 2/28/69 , 19____, to 3/6/69 , 19____, that XX (we) last saw the deceased alive on 3/6/69 , 19____, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) did XXXXXX view the body after death						
22b. SIGNATURE MADHAV D. BARIHANPURKAR, M.D.			22c. DATE SIGNED 3/7/69		22d. PHYSICIAN'S NAME (Type) MADHAV D. BARIHANPURKAR, M.D.	
22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/11/69	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL MEMORIAL Gardens		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR MORAN FUNERAL HOME, 3000 E BALTO ST, BALTO, MD			25a. REC'D BY REGISTRAR MAR 11 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03498

CERTIFICATE OF DEATH

03492

1. DECEASED NAME (Type or print) CLARA MAY HALL			2a. DATE OF DEATH Month 3 Day 14 Year 69			2b. HOUR 5:30 P.M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH May 8, 1888		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 200 Bloomsbury Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 7016 Windsor Mill Rd.		14. FATHER'S NAME First ? Middle ? Last Tarlton					
15. MOTHER'S MAIDEN NAME First Ellen Middle L. Last Jones						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	
16b. SOCIAL SECURITY NO -----		17. INFORMANT Address Mr. John H. Uhler-2040 Summit Ave. Apt. A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE 3 YRS. 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ACUTE UPPER RESPIRATORY INFECTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/28, 1965 to 3/15, 1969 , that (I) (we) last saw the deceased alive on 3/11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul R. Ziegler		DEGREE PAUL R. ZIEGLER		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/15/69	
22d. PHYSICIAN'S NAME (Type) PAUL R. ZIEGLER		22e. ADDRESS 2982 BRIGHTON AVE. BALTO. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 18, '69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City or Town) (County) (State) Randallstown Balto. Md.	
24. FUNERAL DIRECTOR John T. Stansbury, Sr.		ADDRESS -6411 Windsor Mill Rd.		25a. REC'D. BY REGISTRAR MAR. 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
03499					CERTIFICATE OF DEATH					03493				
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH			2b HOUR		
Lulu			B.		Hamilton		3 Month 20 Day 69 Year			6 20		M		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Female		W		9-7-1885			83 YRS							
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
Ohio			U.S.A.					Baltimore Md						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Baltimore 21228				Summit Nursing H.				Housewife						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER				
Md				Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7 Forest Drive				
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last		
Frank			Brown						Hervius			Ida Mae Brown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b SOCIAL SECURITY NO		17 INFORMANT								
				220-44-9152		Mrs. Leonard C. Calders School 7 Forest Drive, 21228								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis												Sudden		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause														
DUE TO, OR AS A CONSEQUENCE OF (b) Delayed death C-V disease												known		
DUE TO, OR AS A CONSEQUENCE OF (c) age														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
Possible Left Basilar pneumonia														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
		HOUR A.M. Month Day Year P.M. 19												
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c LOCATION Street or R.F.D. No City or Town County State										
22a I certify that (I) (this hospital) attended the deceased from June 1964, to 3/20, 1969, that (I) (we) last saw the deceased alive on 3/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death														
22b SIGNATURE														
Clyde Ratliff M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c DATE SIGNED 3/27/69														
22d. PHYSICIAN'S NAME (Type) CLYDE RATLIFF, JR. M.D.						22e ADDRESS 4605 EDMONDSON AVE 21229								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)								
Burial		3/22/69		Meadowridge Cemetery		Baltimore, Maryland								
24 FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229						25a REC'D BY REGISTRAR MAR 21 1969		25b REGISTRAR'S SIGNATURE Charles Judge						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03500

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03494

1 DECEASED NAME (Type or Print) STANLEY E. HAMMOND			2a DATE KNOWN OF DEATH EST. 327-1969			2b HOUR 4A M			
3 SEX Male	4 RACE Black	5 DATE OF BIRTH 2/16/1898	6 AGE (in years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c DATE PRONOUNCED DEAD Month MAR Day 27 Year 1969			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County			
10 CITY OR TOWN OF DEATH White Hall		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Farmer			12a USUAL OCCUPATION (Kind of work done during most of work week, or, even if retired) Farmer		12b KIND OF BUSINESS OR INDUSTRY Own Farm		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b CITY OR TOWN Baltimore		13c CITY OR TOWN White Hall		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First L. E. Middle Grant Last Hammond			15 MOTHER'S MAIDEN NAME First Mary Edith Middle Irene Last Cordery						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give year or dates of service) 220-12-6951			17 INFORMANT Mrs. Ernest Branch, Stewartstown, Pa.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C.C.S.C.V. disease 4134 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. no _____ City or Town _____ County _____ State _____				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE A.M. FRANCE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 3/27/69			
EXAMINER'S NAME (Type) A.M. FRANCE			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) PARKIN BALTO. MD.						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/30/69		23c NAME OF CEMETERY OR CREMATORY Pine Grove U.M.Cem.		23d LOCATION (City or town) (County) (State) White Hall, Balto. Co., Md.			
24 FUNERAL DIRECTOR Genneth W. Fisher				ADDRESS Stewartstown, Pa.		25a REC'D BY REGISTRAR DATE APR 1 1969		25b REGISTRAR'S SIGNATURE Thomas S. Suddal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03501

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03495

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) JESSE			First Middle Last ABONZO HARDEN			2a. DATE OF DEATH Month 3 Day 1 Year 1969			2b. HOUR 57 M		
3. SEX M			4. RACE white			5. DATE OF BIRTH 4-23-95			6. AGE (in years last birthday) 73 YRS		
7a. BIRTHPLACE (State or foreign country) SHAWN-MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY.		
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SPRING-GROVE-S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED-PAINTER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.			13b. COUNTY B. COUNTY			13c. CITY OR TOWN OWINGS MILL			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME JESSE			15. MOTHER'S MAIDEN NAME LUCY			13e. STREET AND NUMBER 37 WENGATE ROAD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO 216-07-686A			17. INFORMANT M. James Harden			Address Owings Mill, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST. 4123 DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED-ARTERIOSCLEROTIC HEART DISEASE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-8, 1968 , to 3-1, 1969 , that (I) (we) last saw the deceased alive on 2-28-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Evelio A Felipe MD			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/1/69		
22d. PHYSICIAN'S NAME (Type) EVELIO A FELIPE MD			22e. ADDRESS SPRING-GROVE-S-HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE March 4, 1969			23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery			23d. LOCATION (City or Town) (County) (State) Randallstown Baltimore MD		
24. FUNERAL DIRECTOR Frank H. Newell			ADDRESS Pikesville, Md.			25a. REC'D BY REGISTRAR MAR 5 1969			25b. REGISTRAR'S SIGNATURE William J. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
45M 1/69

03502		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03496	
Items 15 & 16 Film 10 3/4/69 kk		CERTIFICATE OF DEATH					
1 DECEASED NAME (Type or print) First Middle Last MARY A HARNER			2a DATE OF DEATH MAR. Month 2 Day 69 Year			2b HOUR 8 P M	
3. SEX F. M.		4. RACE WHITE		5 DATE OF BIRTH OCT. 31, 1897		6. AGE (In years last birthday) 71 YRS.	
7a BIRTHPLACE (State or foreign country) PA.		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH PIKESVILLE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 741 LEAFDALE TER.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE PA.		13b COUNTY V ADAMS CO. GETTYSBURG		13c CITY OR TOWN GETTYSBURG		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 12 SOUTH WASHINGTON		14 FATHER'S NAME First Middle Last ADAM SCHULTZ		15 MOTHER'S MAIDEN NAME First Middle Last SARAH STOKER		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO	
16b SOCIAL SECURITY NO 146-10-9923		17 INFORMANT CLAUDINE E. HALE		Address 741 LEAFDALE TERRACE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction							
4109 DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/2, 1969, to 3/2, 1969, that (I) (we) lost saw the deceased alive on 8:55 PM 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur A Serpick MD DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/2/69	
22d. PHYSICIAN'S NAME (Type) Arthur A Serpick				22e. ADDRESS 5601 Old Court Rd Balto Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 5, 69		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS Cem.		23d. LOCATION (City or Town) (County) (State) LITTLESTOWN PA.	
24. FUNERAL DIRECTOR LORING BYERS 8728 LIBERTY RD RANDALSTOWN				25a. REGD BY REGISTRAR DATE MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03503 CERTIFICATE OF DEATH 03497									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P. M.
WILLIAM HENRY MAYDEN						March 12 1969			5:00 P. M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		August 29, 1889		79 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD			VETERANS ADMINISTRATION HOSPITAL			BARTENDER			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1452 Light Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George Hayden			Louise Schulhard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes WW-1			217 01 8885		Clinical Rcds, VA Hospital, Fort Howard, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE HEAD OF THE PANCREAS WITH METASTASIS TO LIVER									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Dec. 16, 1968, to Mar. 12, 1969, that (X) (we) last saw the deceased alive on Mar 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Madhav S. Barnharpurkar DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/13/69		
22d. PHYSICIAN'S NAME (Type) MADHAV D. BARNHARPURKAR, M.D.					22e. ADDRESS VA Hospital, Fort Howard, Md.				
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/17/69		Baltimore National		Baltimore, Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ZANNINO FUNERAL HOME		257 S. Conkling St. Baltimore, Md.		MAR 14 1969		Charles Judge			

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1

03504

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03498

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH			2b HOUR	
JOSEPH			V.	HEIDLER	SR.	3	Month 5	Day 69	Year 00 7: p M
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Cau		MARCH 23, 1908		60 YRS		MONTHS	DAYS	HOURS MIN.
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.		
PA.	USA				Baltimore				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Center		ROOFING CONTRACTOR		ROOFING			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER			
PA.		YORK		YORK		780 HILLCREST RD.			
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
HENRY				HEIDLER	ROSE				STRAUSBAUGH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No		175-10-2351		JOSEPH V. HEIDLER JR.		YORK, PA. 470 QUAKER DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive bronchopneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of tonsils with widespread metastases</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/3</u> , 19 <u>69</u> , to <u>3/5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED			
						3/6/69			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
Rudiger Breiteneker, M.D.		6701 N. Charles Street							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		MARCH 8, 1969		HOLY SAVIOUR CEMETERY		YORK YORK PA.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
JOHN W. KEFFER		YORK, PA. 902 MT. ROSE AVE		DATE MAR 10 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 5/11/69
30M REV 100

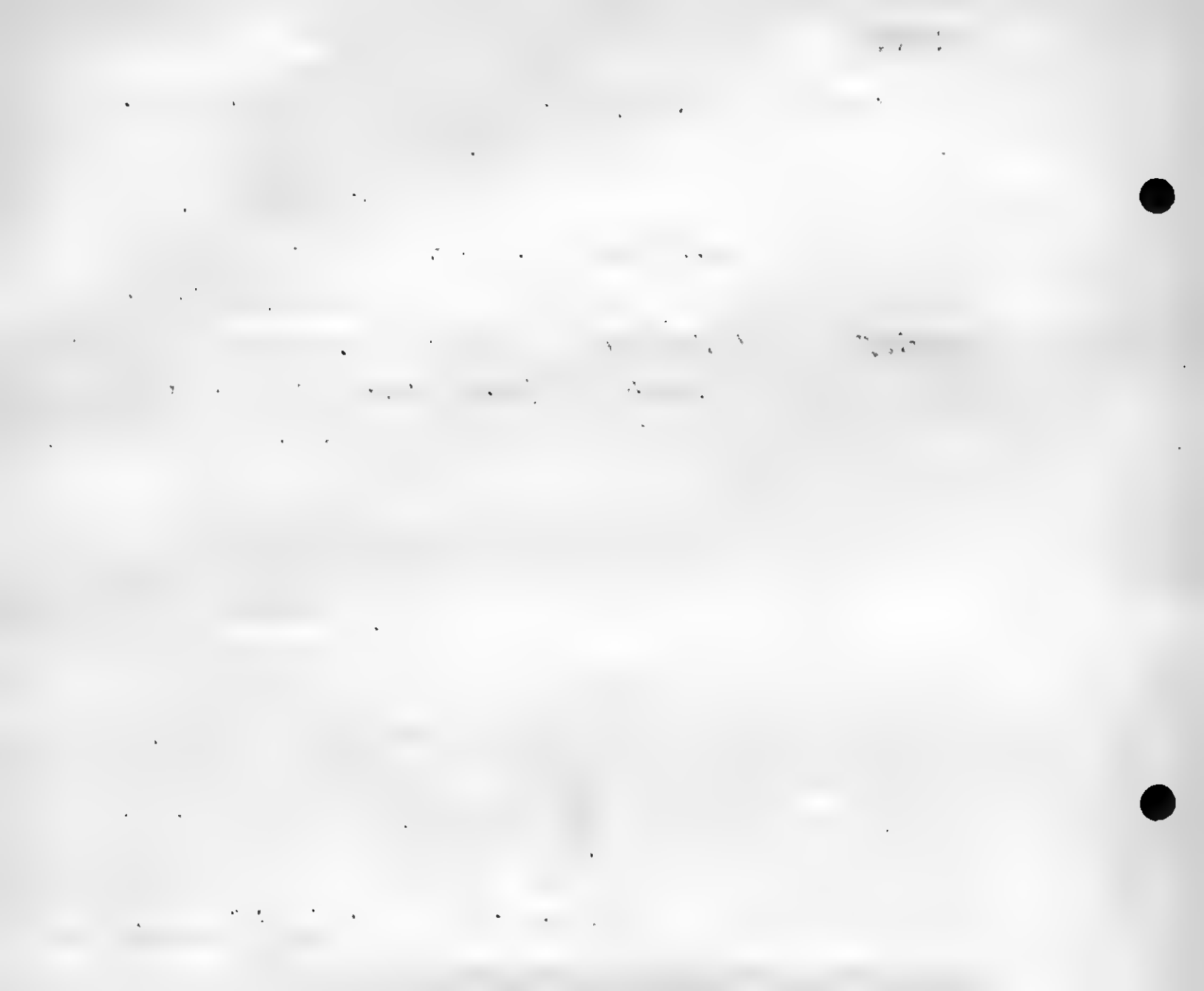
03505

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03499

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GRACE ORENE HEIGER			2a. DATE OF DEATH Month MARCH Day 26 Year 1969			2b. HOUR 10 a. M.			
3 SEX F		4 RACE W		5 DATE OF BIRTH APRIL 7, 1894		6 AGE (in years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS 74 DAYS 74 HOURS 74 MIN	
7a BIRTHPLACE (State or foreign country) VIRGINIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. COUNTY GENERAL H		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HUSBAND		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3504 ESSEX RD.	
14. FATHER'S NAME First GEORGE Middle JOHN Last SON			15. MOTHER'S MAIDEN NAME First EMMA Middle BALPERSON Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 212-24-9998		17. INFORMANT HERMAN HEIGER		Address 3504 ESSEX RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic heart disease 412.5 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/14, 1944 to 3/26, 1969 , that (I) (we) last saw the deceased alive on 3/19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Robert A. Reiter M.D. DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 3/27/69					
22d. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.				22e ADDRESS 606 Edmondson Ave. 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-29-69		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD			
24. FUNERAL DIRECTOR WEBER FUNERAL HOME		25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]					



03506

CERTIFICATE OF DEATH

03500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ELIZABETH				HILBERG	Mar 9, 1969		2:45 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	Caucasian		28 July 1872		96 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Germany	U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				
Overlea		9 Willow Ave.		at home				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Balto.		Overlea		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9 Willow Ave.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last					
Heinrich Greif			Anna C. Becker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no		216-56-7254		Mrs. Bertha Bretall 9 Willow Ave. 21206				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>								48 hrs
4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>								15 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 1</u> , 19 <u>69</u> , to <u>Mar 9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Charles M. Kerr MD</u>				22c. DATE SIGNED <u>Mar 10, 69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Charles M. Kerr, MD</u>				22e. ADDRESS <u>6801 Belair Rd.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		12 Mar 69		Mt. Carmel Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Ulrich funeral Home, Balto., Md.				MAR 13 1969		<u>Charles M. Kerr</u>		

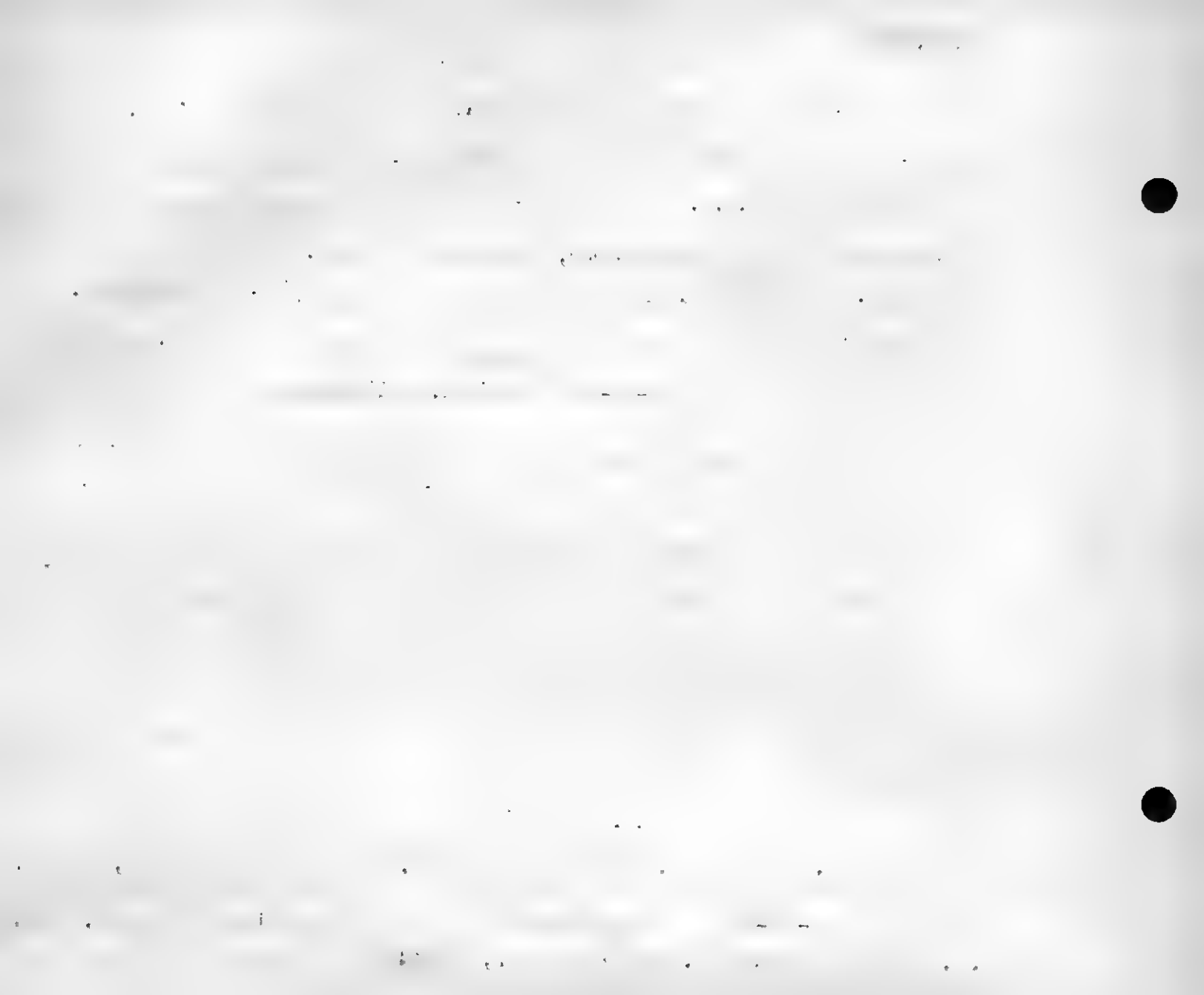


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Angelica Rogge Hilgenberg						March 22 1969			11 A M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN
Female		White		August 7, 1877			91 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Baltimore County Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Lutherville			College Manor, Lutherville			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER
Md.			Baltimore			YES			808 W. Belvedere Ave.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Christian Rogge			Mathilde Scholmann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			212-01-5412			Carl R. Hilgenberg			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Year</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASCD</u> <u>Year</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/67</u> , 19 <u>67</u> , to <u>3/22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>RK Gundry MD</u>						22c. DATE SIGNED 3/25/69		22d. PHYSICIAN'S NAME (Type) Dr. Richard K. Gundry	
22e. ADDRESS 2 W. University Parkway, Balto.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			3-27-69			Druid Ridge			Pikesville Balto. Md.
24. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd., Balto.						25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE <u>J. J. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03508

CERTIFICATE OF DEATH

03502

1 DECEASED-NAME (Type or print) IDA L. AGUES			First Middle Last			2a DATE OF DEATH March Month 2 Day 1969 or 12:25 2b HOUR		
3. SEX Female		4 RACE White		5. DATE OF BIRTH 6-7-1885		6. AGE (In years lost today) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived if institution Residence before address) - STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1546 Northbourne Road
14 FATHER'S NAME Joseph Lacher			First Middle Last			15 MOTHER'S MAIDEN NAME Margaret Young		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 212-10-0970D		17 INFORMANT Margaret Hoarn, 1546 Northbourne Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Right coronary thrombosis Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Right cerebral encephalomalacia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that 10 (this hospital) attended the deceased from Feb 9 , 19 69 , to March 2 , 19 69 , that 41 (we) last saw the deceased alive on March 2 , 19 69 , and that in 104 (our) opinion death occurred on the date and hour and from the causes stated above. 10 (we) (did) (XXXXX) view the body after death.								
22b. SIGNATURE Cilliani				DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-2-69
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.				22e. ADDRESS 7620 York Road, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-5-69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Balto., Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.				ADDRESS		25a. REC'D BY REGISTRAR MAR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

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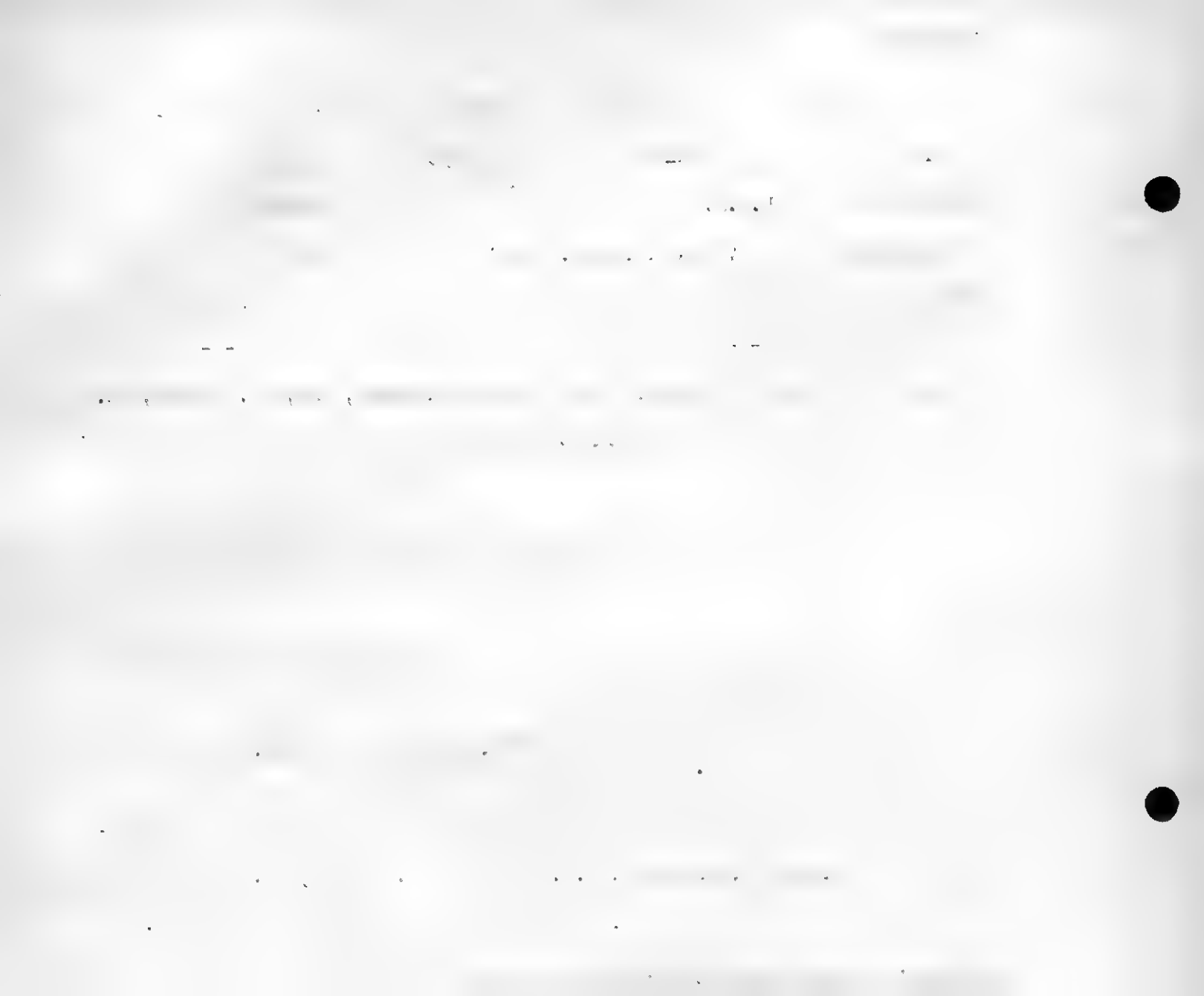
03509

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03503

1 DECEASED NAME (Type or print)		First FRED	Middle PHILLIP	Last HOLT	2a. DATE OF DEATH Month MARCH Day 29 Year 1969		2b. HOUR 11:04A M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5/8/98		6. AGE (In years last birthday) 70 YRS	
7a. BIRTHPLACE (State or foreign country) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SHOE CUTTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INS DE CITY, JMWTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 810 POWERS STREET		14. FATHER'S NAME First FRANK Middle - - Last HOLT		15. MOTHER'S M A D E N NAME First MARY Middle - - Last - -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO (If yes give year or dates of service) WWII		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNGS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB. 13, 1969 , to MAR. 29, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAR. 29, 1969 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.							
22b. SIGNATURE <i>Gracito V. Patricio</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/29/69	
22d. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO, M.D.				22e. ADDRESS VAH, FT. HOWARD, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-2-69		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR FRANK W. SEITZ				ADDRESS 814 W. 36th ST., BALTO., MD.		25a. APPROVED BY REGISTRAR APR 2 1969 DATE	
				25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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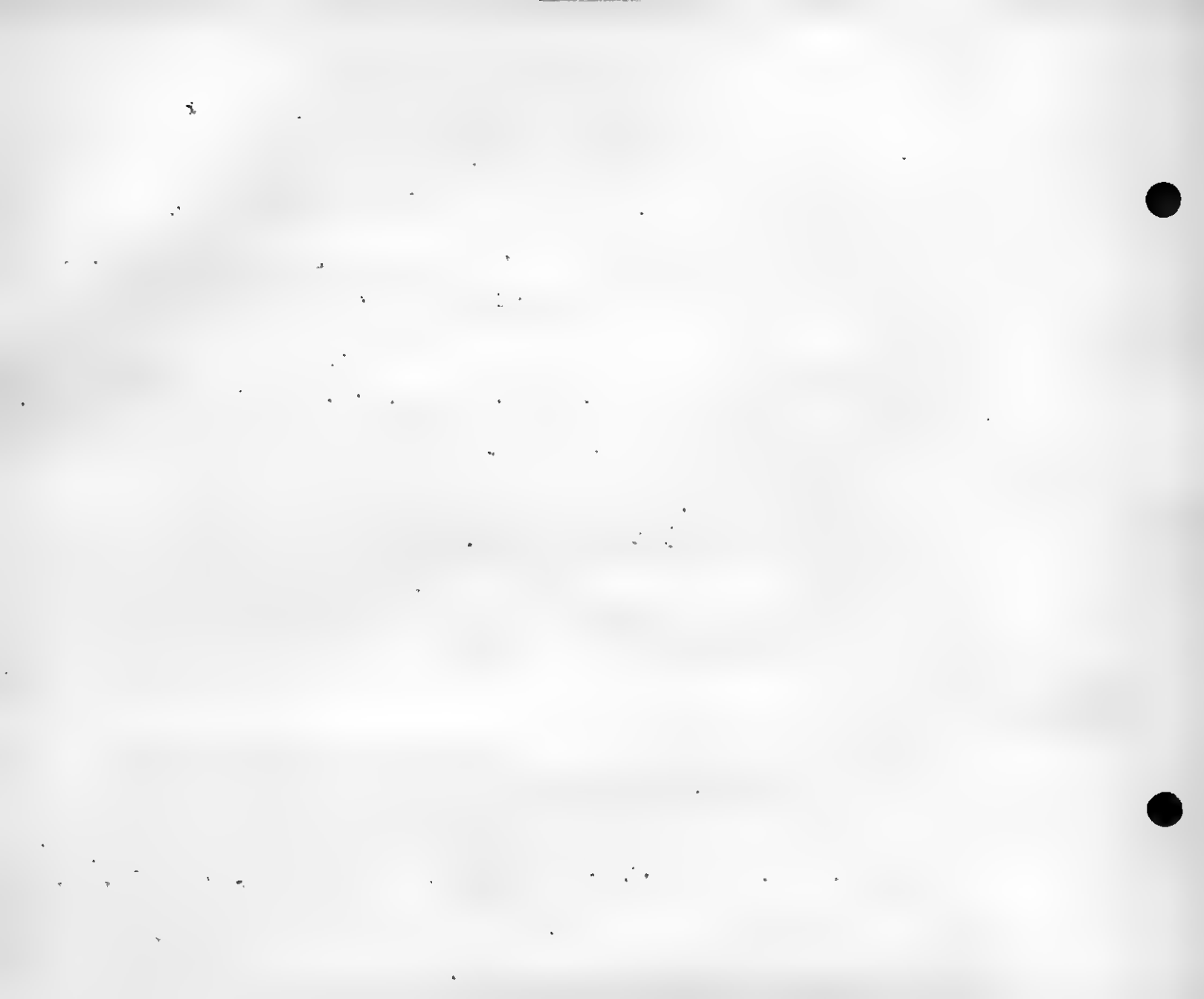
03510

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03504

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Lillian Elizabeth Holtz					March 22, 1969		7 P M	
3. SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN
Female	White		Jan. 8, 1897		72 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland	U. S. A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospita. give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		307 Roanoke Drive		Candy dipper Martha Wash. Candy Co.				
13a. USUAL RESIDENCE (Where deceased lived, if not in hospita. admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER		
Maryland		Baltimore		Catonsville		307 Roanoke Drive		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
William A. Holtz				Ella B. Foster				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		18 ADDRESS		
No		213-03-3631		Mrs. Grace E. McConville		21207 Beechwood Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lemoning thru train</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A. S. C. V. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs ? 5 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1964</u> , to <u>March 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE <u>D. C. MacLaughlin</u>				DEGREE ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/25/69</u>
22d. PHYSICIAN'S NAME (Type) Dr. D. C. MacLaughlin M.D.				22e. ADDRESS 303 N. Rolling Road Catonsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3/26/1969		Druid Ridge Cemetery		Reisterstown, Maryland		
24 FUNERAL DIRECTOR <u>Easton Funeral Home</u>				ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>

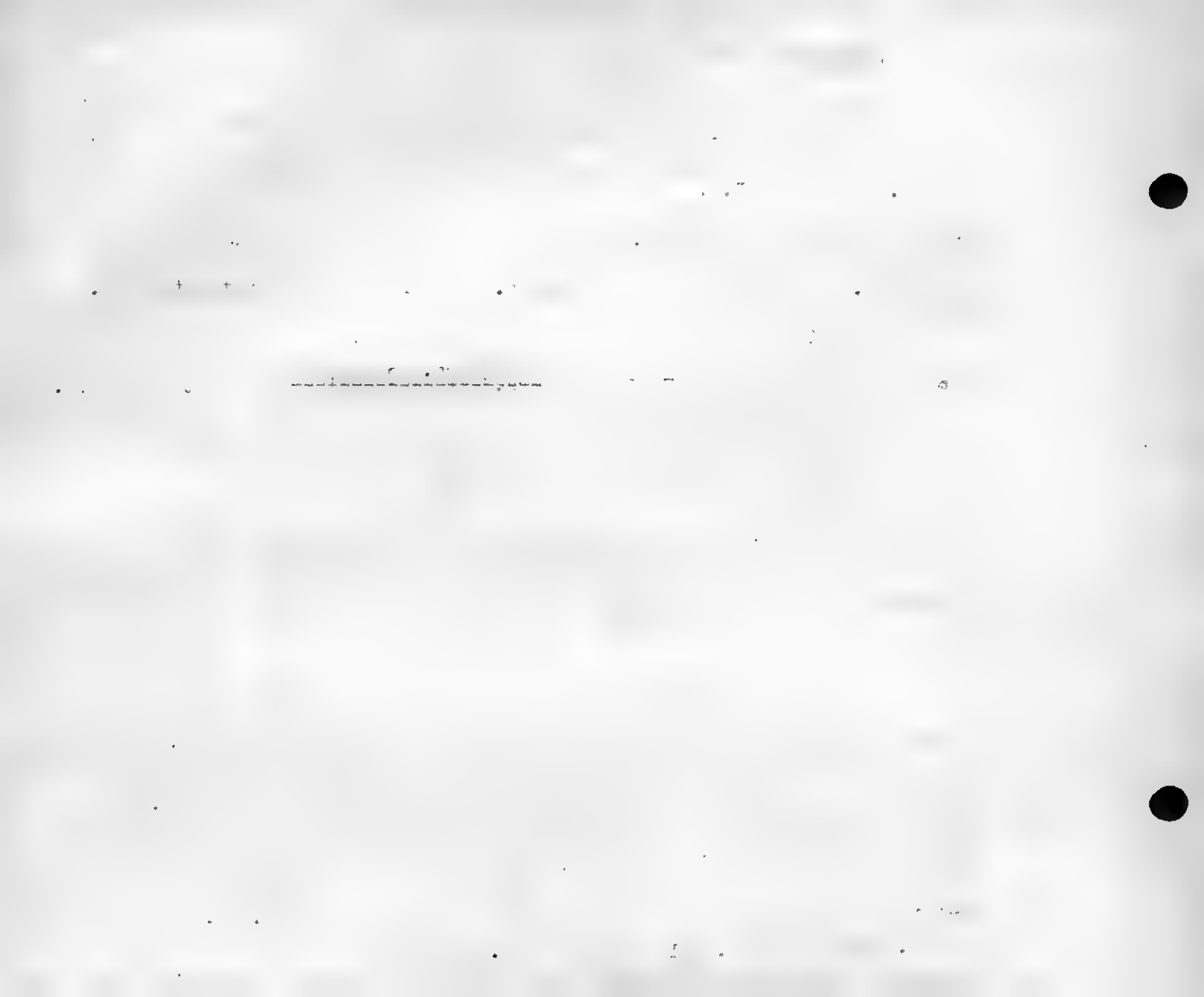


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 4 Filing No. 3/18/69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 035111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										03505			
1 DECEASED NAME (Type or Print) James E. Hood						2a DATE KNOWN OF DEATH <input type="checkbox"/> EST <input type="checkbox"/> MATED <input type="checkbox"/> 3 10 1969		2b HOUR <input type="checkbox"/> 1969					
3 SEX M		4 RACE White		5 DATE OF BIRTH 9-1-21		6 AGE (In years last birthday) 47 YRS		7c DATE PRONOUNCED DEAD Month 3 Day 10 Year 1969		2d HOUR 1 A M			
7a BIRTHPLACE (State or foreign country) Md.				7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Sparrows Point				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Plant Dispensary				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Railroad Conductor				12b KIND OF BUSINESS OR INDUSTRY Steel Making	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.				13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3025 Huntington Ave.			
14 FATHER'S NAME First ? Middle ? Last ?						15 MOTHER'S MAIDEN NAME First ? Middle ? Last ?							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b SOCIAL SECURITY NO. 220-05-3167		17. INFORMANT Mrs. Boma Hood ADDRESS 3025 Huntington Ave.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF ACUD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost ACUD DUE TO, OR AS A CONSEQUENCE OF ACUD (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION N				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? N				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No		City or Town		County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Theo C. Patterson				EXAMINER'S NAME (Type) THEO C. PATTERSON				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/10/69		ADDRESS (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Burial				23b DATE 3/13/69		23c NAME OF CEMETERY OR CREMATORY National				23d LOCATION (City or Town) Balto. Md.		(County) (State)	
24 FUNERAL DIRECTOR Paul E. Chenoweth						ADDRESS 3rd. 3617 Chestnut Ave.		25a REC'D BY REGISTRAR MAR 13 1969		25b REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-

03512

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03506

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
Martin				Houseman	03 Month 03 Day 69 ^{ear}		9:25 ^{PM}	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male	white		04/08/13		55 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
BALTIMORE, MARYLAND		U.S.A.				Baltimore Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of year, not even retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Balto. Cnty. General		STOREKEEPER		MD. STATE		
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Balto.		RANALISTOWN		3911 Algiers Rd.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
DAVID				HOUSEMAN	LILLIAN			?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT Address				
NO		218-22-0417		MRS. FRANCES HOUSEMAN, 3911 ALGIERS RD. #21133				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>								151
2509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>								5 yrs
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Diabetic Mellitus</u>								5 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>November, 1963</u> , to <u>3-03-1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
George M. Ramaguram								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
George M. Ramaguram		3502 Croydon Rd, Balt, 21201						
23a. BURIAL CREMATION, BURY (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		3-6-69		BETH EL MEMORIAL PARK		RANDALISTOWN, MARYLAND		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. DATE		
J. L. Lennison & Bros		6010 REISERTOWN		MAR 10 1969				

VR A15
45M - 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03513		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03507	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
George		Darby	Huggins		03 Month 02 Day 69 ^{year}		1:25 ^{PM}
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	White		11/19/00		68 YRS		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania.	U.S.A.			Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore Co.		Baltimore County Gen.		Retired		B & O RR	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER		
Md.		Balto.	Balto.		6425 Gilmore Ave.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
(Dec. Edwin		B.	Huggins		Martha Wilson (dec.)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
Yes		6/3/19-1921		Mrs. George D. Huggins, 6425 Gilmore St		Woodlawn, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute antero lateral MI</u>							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
<u>none</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
5		C		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <u>1205 3/2/69</u> , 19 <u>69</u> , to <u>125 3p</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE <u>E. Henderson</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>3/2/69</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		3-5-69		Meadowridge		Balto. County, Md.	
24 FUNERAL DIRECTOR <u>H. E. ...</u>		25a MAR BY REGISTRAR <u>4 1969</u>		25b REGISTRAR'S NAME <u>Charles Judge</u>			

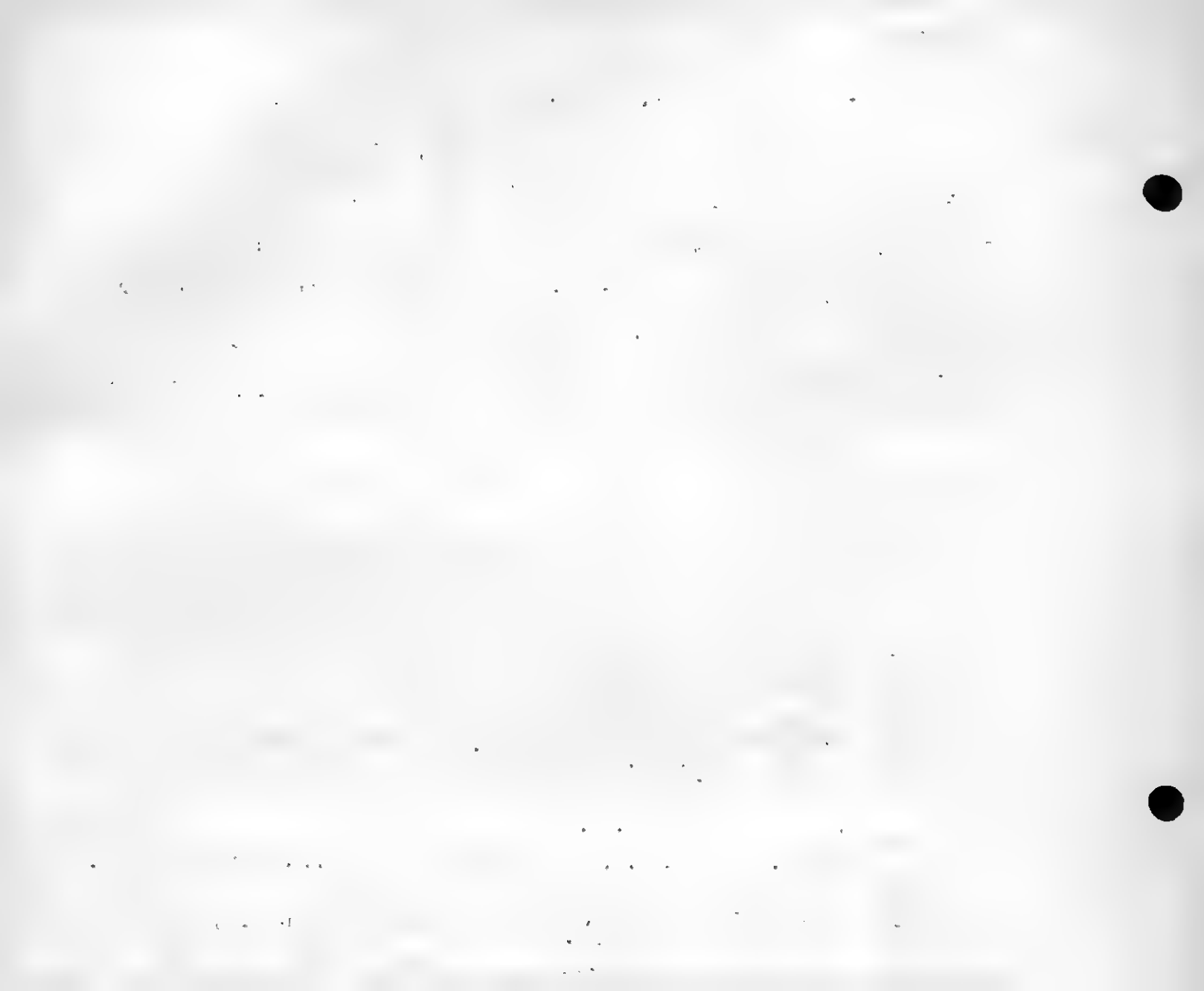


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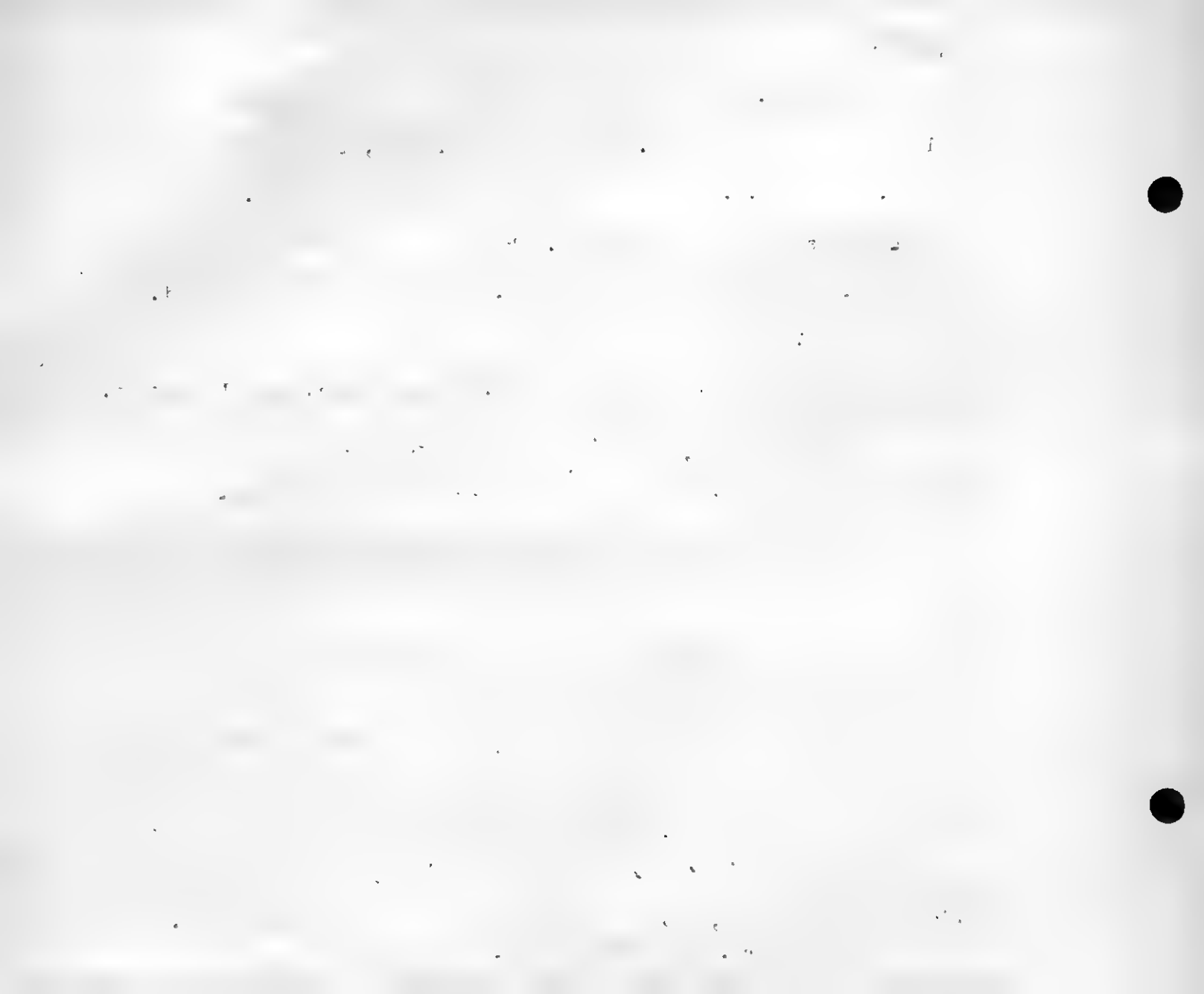
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30M REV. 1-68

03514		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03508			
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
MONNIE JEANNETTE HUGHES						MARCH 12 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		AUG 20, 1875		93 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
MARYLAND		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		3440 RIPPLE ROAD		AT HOME					
13a. USUAL RESIDENCE (Where deceased administered) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		BALTO				3440 RIPPLE ROAD #7	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
					FLOYD				HARDICAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, in <input type="checkbox"/> (If yes give war or dates of service) NO <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
			NO			ETHEL KNIGHT - 3440 RIPPLE ROAD # 7			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
4124 IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
And conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>ASCVD</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) had attended the deceased from <u>Feb.</u> , 19 <u>60</u> , to <u>March</u> , 19 <u>69</u> , that (I) had last saw the deceased alive on <u>March 1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
<u>John J. Darrell, M.D.</u>						3/13/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
John J. Darrell, M.D.						9017 Liberty Rd., Randallstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
BURIAL		3-15-69		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Harold J. Leight</u>						MAR 18 1969		<u>William J. Leight</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban paper (page 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03515										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03509									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Harry C. Hull										3/10/69 Month Day Year										1:15 P.M.									
3 SEX Male			4 RACE Cauc.			5. DATE OF BIRTH April 28, 1885			6 AGE (In years lost last day) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN														
7a BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balto.																				
10. CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) House in the Pines			12a USUAL OCCUPATION (Kind of work done during most of working life; retired) Retired			12b KIND OF BUSINESS OR INDUSTRY																				
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b COUNTY Calvert			13c CITY OR TOWN Balto.			13d INSIDE CITY LIM 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 3341 Paine St.																	
14. FATHER'S NAME First Middle Last ?					15 MOTHER'S MAIDEN NAME First Middle Last ?																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)					16b. SOCIAL SECURITY NO 215-17-6739					17 INFORMANT Address Mrs. Estella Sullivan 3341 Paine St.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 3-22-1968 , to 3-10-1969 , that (I) (we) last saw the deceased alive on 3-10-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Wilmer K. Gallagher M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 3-10-69																			
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.										22e. ADDRESS 6209 Frederick Ave. Balt., Md 21228																			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial					23b. DATE March 14, 1969					23c. NAME OF CEMETERY OR CREMATORY Meadow Branch					23d. LOCATION (City or town) (County) (State) Carroll Co.														
24. FUNERAL DIRECTOR Paul E. Chonoweth 3rd. 3617 Chestnut Ave.										25a. REC'D BY REGISTRAR DATE MAR 13 1969					25b. REGISTRAR'S SIGNATURE W. J. Sullivan														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
03516		CERTIFICATE OF DEATH						03510				
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		2b HOUR	
EDWARD			RICHARD		HUNEKE		MARCH		17, 1969		6:12 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 2 YRS	
MALE		WHITE		10 19 10			58 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CIT ZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
MARYLAND			U.S.A.						BALTIMORE, MARYLAND Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD			VETERANS ADMINISTRATION HOSP.			BREAD SALESMAN			Bakery			
13a USUAL RESIDENCE (Where deceased lived at time of death) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND						BALTIMORE				4804 ALTHEA AVENUE		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			
CHARLES			W.		HUNEKE				AUGUSTA (MN: UNKNOWN)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT Address						
YES			WW-II			216 09 7311 CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST												
DUE TO, OR AS A CONSEQUENCE OF POST-OP PNEUMONECTOMY												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF CARCINOMA, RIGHT LUNG.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
5/17/69		CARCINOMA RIGHT LUNG				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No		City or Town		County		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												
22a I certify that (X) (this hospital) attended the deceased from Feb. 11, 1969, to March 17, 1969, that (X) (we) last saw the deceased alive on March 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (saw) view the body after death												
22b SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
George C. McElPatrick M.D.										3 18 69		
22d PHYSICIAN'S NAME (Type)						22e ADDRESS						
GEORGE C. McELPATRICK, M.D.						VET. ADM. HOSP., FT. HOWARD, MARYLAND						
23a BURIAL CREMATION, (Type)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)		
BURIAL		Mar. 21, 1969		JERUSALEM CEMETERY		BALTIMORE				MARYLAND		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG. STRAR		25b REG. STRAR'S SIGNATURE						
Ullrich Funeral Home		4210 Belair Rd. Baltimore, Maryland		MAR 24 1969		Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
45M 1X69

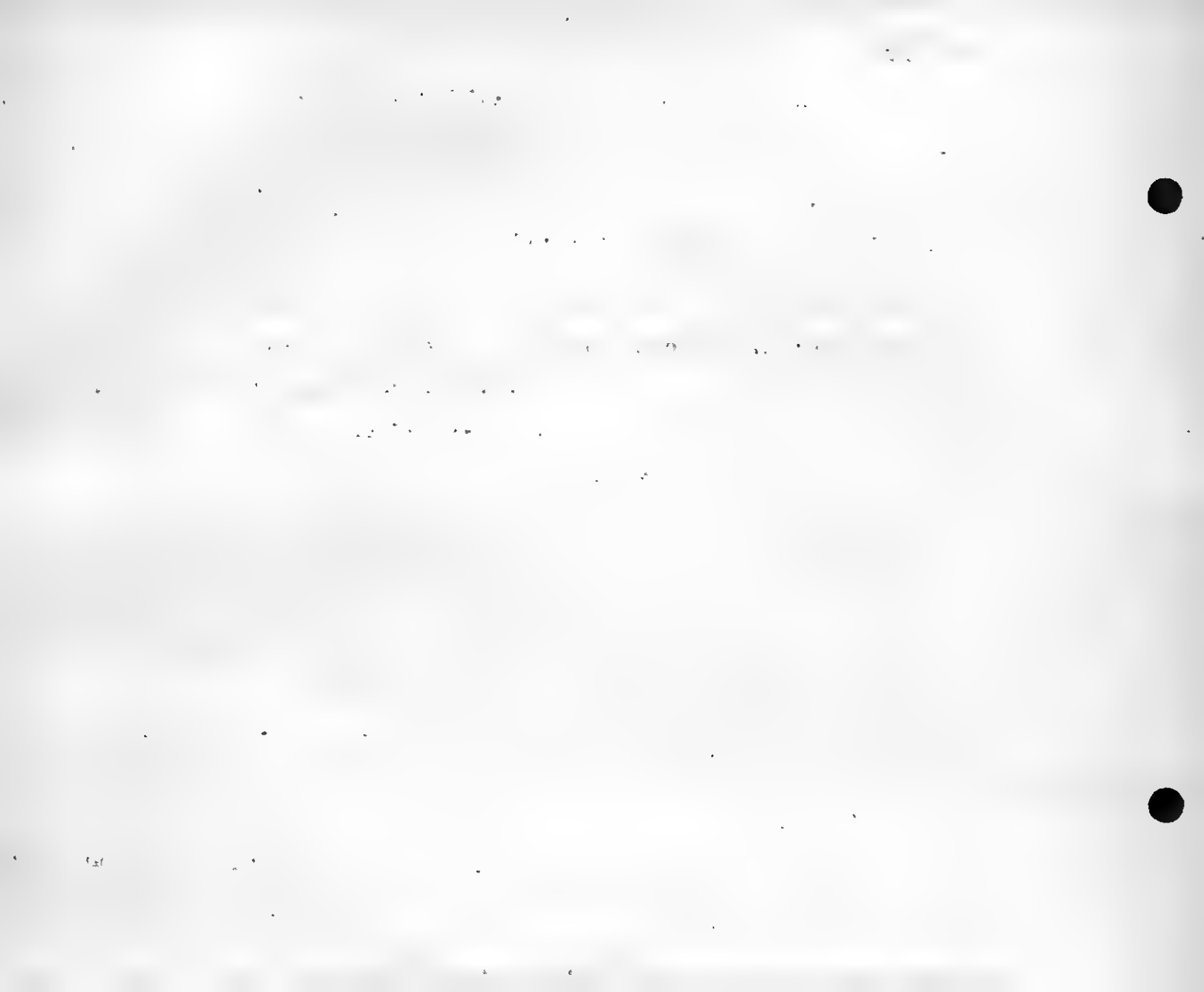
03517		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03511	
1 DECEASED-NAME (Type or print)		First ERNEST	Middle EARL	Last HUPPMAN	2a. DATE OF DEATH MARCH Month 7 Day 1969		2b. HOUR 1:30 PM
3. SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH 3/4/96		6 AGE (In years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL		12a USAL OCCUPATION (Kind of work done or most of working life, even if retired) PAINTER		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY 12		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2120 EASTERN AVENUE	
14 FATHER'S NAME First JOHN Middle HUPPMAN Last HUPPMAN		15 MOTHER'S MAIDEN NAME First MARY Middle HUPPMAN Last HUPPMAN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) YES (If yes give year and dates of service) WWI 222 01 20 22			
16b SOCIAL SECURITY NO 222 01 20 22		17 INFORMANT CLINICAL RECORDS VAH FORT HOWARD, MARYLAND					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 157.7 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMATOSIS, ABDOMINAL, PROBABLY SECONDARY DUE TO, OR AS A CONSEQUENCE OF (c) TO CARCINOMA OF PANCREAS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) PYELONEPHRITIS RIGHT SIDE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that A (this hospital) attended the deceased from 2/7/69 , 19 19 , to 3/7/69 19 19 , that (he) last saw the deceased alive on 3/7/69 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Madhav S. Barhanpukar		22c. DATE SIGNED 3/8/69		22d. PHYSICIAN'S NAME (Type) MADHAV BARHANPUKAR, M. D.			
22e. ADDRESS VA HOSPITAL FORT HOWARD, MARYLAND		22f. ADDRESS VA HOSPITAL FORT HOWARD, MARYLAND					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR BRUZDZINSKI FUNERAL HOME		24b. ADDRESS 1407 EASTERN AVE., BALTO., MD.		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03518 CERTIFICATE OF DEATH 03512													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
BABY GIRL HUTSCHENREUTER						MARCH 25 Day 69 Year			1:50 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
FEMALE		White		March 23, 1969			YRS.		1		5 23		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Baltimore, Md.			USA						BALTIMORE			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital address required)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE			CR. BALTO. MED. CENTER										
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Penna.			York			Airville			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. 2	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Fred erick H. Hutschenreuter			Bessie Bebnam										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
						F.H. Htschenreuter, Airville, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE													
7762 DUE TO, OR AS A CONSEQUENCE OF IMMATURITY													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 3-23, 19 69, to 3-25, 19 69, that (I) (we) lost saw the deceased alive on 3-25-69 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Meshkinpur								DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-25-69			
22d. PHYSICIAN'S NAME (Type) DR. H. MESHKINPUR								22e. ADDRESS 6701 N. CHARLES ST. BALTO, MD 21204					
23a. BURIAL, CREMATION BENQUA (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		March 27, 1969		Pine Grove				Sunnyburn York Pa					
24. FUNERAL DIRECTOR John H. Haskins				ADDRESS Delta, Penna.				25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03519

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03513

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First JAMES	Middle HENRY	Last Irvin IRVIN, SR.	2a. DATE KNOWN OF ESTI- DEATH: MATED <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> March 28, 1969		2b. HOUR 1:30 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH Dec. 7, 1902	6 AGE (In years last birthday) 66 YRS	7. UNDER YEAR MONTHS OAYS	8. UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year March 28, 1969	2d. HOUR 1:30 PM
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Overlea		11. NAME OF HOSPITAL OR INSTITUTION (if not in hosp tal give street address) 607 Old Home		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Boiler Operator Gas & Electric		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY - HITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER 607 Old Home	
14. FATHER'S NAME First Middle Last James H. Irvin			15. MOTHER'S MAIDEN NAME First Middle Last Nellie --				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-07-6586		17. INFORMANT Flornel Shipley - 3337 Willoughby Rd. -21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of Abdomen DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. Unk. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Shot self			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No City or Town County State 607 Old Home Balto. M.D.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opin an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Ronald N. Kornblum		EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street city town or county)		22b. DATE SIGNED 3/29/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-31-69		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206				25a. REC'D BY REG STRAR DATE APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03520

03514

1 DECEASED-NAME (Type or print) Elizabeth Jacobs		First Middle Last		2a DATE OF DEATH 3/18/69		2b HOUR 7:30 P M		
3 SEX F	4 RACE W		5 DATE OF BIRTH 4/24/00		6 AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shadybrook Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) clerk		12b KIND OF BUSINESS OR INDUSTRY Ross-Matthias		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Balto		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 418 North Bend Road		14 FATHER'S NAME First Middle Last Delosier		15 MOTHER'S MAIDEN NAME First Middle Last ---				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO (If yes give war or dates of service) 213-34-3825		17 INFORMANT Mrs. Mary Ward, 418 North Bend Road, 21229		Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Labor pneumonia Left Base DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (c) CVA RT. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2/22, 1968, to 3/18, 1969, that (I) (we) last saw the deceased alive on 3/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE Cliff Ratliff				22c. DATE SIGNED 3/19/69		22d. PHYSICIAN'S NAME (Type) Dr. Cliff Ratliff		
22e. ADDRESS 4605 Edmondson Ave,				22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Avenue, 21229				25a. REC'D BY REGISTRAR DATE MAR 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

03521

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03515

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	Sr.	2a DATE OF DEATH			2b HOUR		
GEORGE E Simms		JENKINS				Month	Day	Year	7:15 AM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS		8 IF UNDER 24 HRS HOURS MIN		
MALE	CAUC		2-17-87		82 YRS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.A.				BALTO					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
TOWSON		CHESAPEAKE MANOR		Retired Auditor							
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.		Baltimore		Baltimore				4522 N. Charles St.			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
John J. Jenkins		Mary A. Simms									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address							
No		215-05-5418A		J. Richard Jenkins 213 Rodgers Forge Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of prostate.										6 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease										5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
None				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from June, 1948, to Present, 1969, that (I) (we) last saw the deceased alive on 2/21/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED									
J. Emmett Lucien		3/4/69									
22d PHYSICIAN'S NAME (Type)		22e ADDRESS									
J. EMMETT		QUEEN BAR SEASONS 2105 P									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		3/6/1969		Cathedral Cemetery		Baltimore Balto. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE					
MITCHELL WEDEFELI		6500 York Rd.		MAR 11 1969		J. Charles, Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03522

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03516

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First THOMAS	Middle HAYWOOD	Last JENKINS	2a. DATE OF DEATH Month MARCH Day 9 Year 1969			2b HOUR 3:40 AM
3 SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MAY 4, 1895		6. AGE (In years lost birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) VIRGINIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not, give street address) HOSPITAL VETERANS ADMINISTRATION		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) FLOOR FINISHER		12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13a USUAL RESIDENCE (Where deceased lived, admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2544 WILKENS AVENUE	
14 FATHER'S NAME First WILLIAM			Middle E	Last JENKINS		15. MOTHER'S MAIDEN NAME First ALICE			Middle IACHER
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b SOCIAL SECURITY NO WW 1		17 INFORMANT CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD		Address			
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that VA (this hospital) attended the deceased from 2/27/69 , 19____, to 3/9/69 , 19____, that XX (we) last saw the deceased alive on 3/9/69 , 19____, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) XXXX view the body after death									
22b. SIGNATURE Madhav D. Barhanpurkar					22c. DATE SIGNED 3 9 69		22d. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.		
22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND									
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 3/12/69		23c. NAME OF CEMETERY OR CREMATORY Culpeper National Cem.		23d. LOCATION (City or Town) (County) (State) Culpeper, Virginia			
24. FUNERAL DIRECTOR EVERLY FUNERAL HOME, FAIRFAX, VIRGINIA					25a. REC'D BY REGISTRAR DATE MAR 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV. 1-54

03523										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03517																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
Eva M. Johnson										3 Month 20 Day 69 Year										745 M																			
3. SEX Female										4 RACE Caucasian										5. DATE OF BIRTH March 28, 1902																			
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																			
9. COUNTY OF DEATH Baltimore										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Keeper										12b. KIND OF BUSINESS OR INDUSTRY																			
10. CITY OR TOWN OF DEATH Parkville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8704 Summit Avenue										13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland																			
13b. COUNTY Baltimore										13c. CITY OR TOWN										13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
13e. STREET AND NUMBER 8704 Summit Avenue										14. FATHER'S NAME First Middle Last Charles Johnson										15. MOTHER'S MAIDEN NAME First Middle Last Mary Agnes Scott																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO 215-24-9686A										17. INFORMANT Address Theodore J Scholtholt Same																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma																																							
1070										DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Hypernephroma of Kidney																													
										DUE TO, OR AS A CONSEQUENCE OF										(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Feb, 1969, to 3.20, 1969, that (I) (we) last saw the deceased alive on 3 4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 3.20.69																			
22d. PHYSICIAN'S NAME (Type) Keith A. Manley M.D.										22e. ADDRESS 2045 York Road																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 3/24/69										23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer										23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland									
24. FUNERAL DIRECTOR										ADDRESS Leonard J. Ruck Inc. 5305 Harford Road 21214										25a. REC'D BY REGISTRAR DATE APR 24 1969										25b. NEWSPAPER'S SIGNATURE									



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours, after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03524 Item 13a thru e Film MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03518									
1. DECEASED NAME (Type or Print) First Middle Last RICHARD HENRY JOHNSON						2a. DATE KNOWN OF DEATH Month Day Year March 3 9 1969		2b. HOUR 6:10	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 5/9/1901	6. AGE (In years last birthday) 68 YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year March 9 1969		2d. HOUR 6:10	
7a. BIRTHPLACE (State or foreign country) Richmond, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sheppard Pratt Hospital			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia Md.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 1100 Oak Lane Avenue Hampton Gard.			
14. FATHER'S NAME First Middle Last Richard Henry Johnson				15. MOTHER'S MAIDEN NAME First Middle Last Henrietta Watkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wm. T. Johnson - Richmond, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3/10/69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-10-69		23c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery		23d. LOCATION (City or Town) (County) (State) Richmond, Va.			
24. FUNERAL DIRECTOR ADDRESS Wm. J. Trichner & Sons, Balto., Md.				25. PREPARED BY REGISTRAR Mar 14 1969		25b. REGISTRAR'S SIGNATURE James			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

1

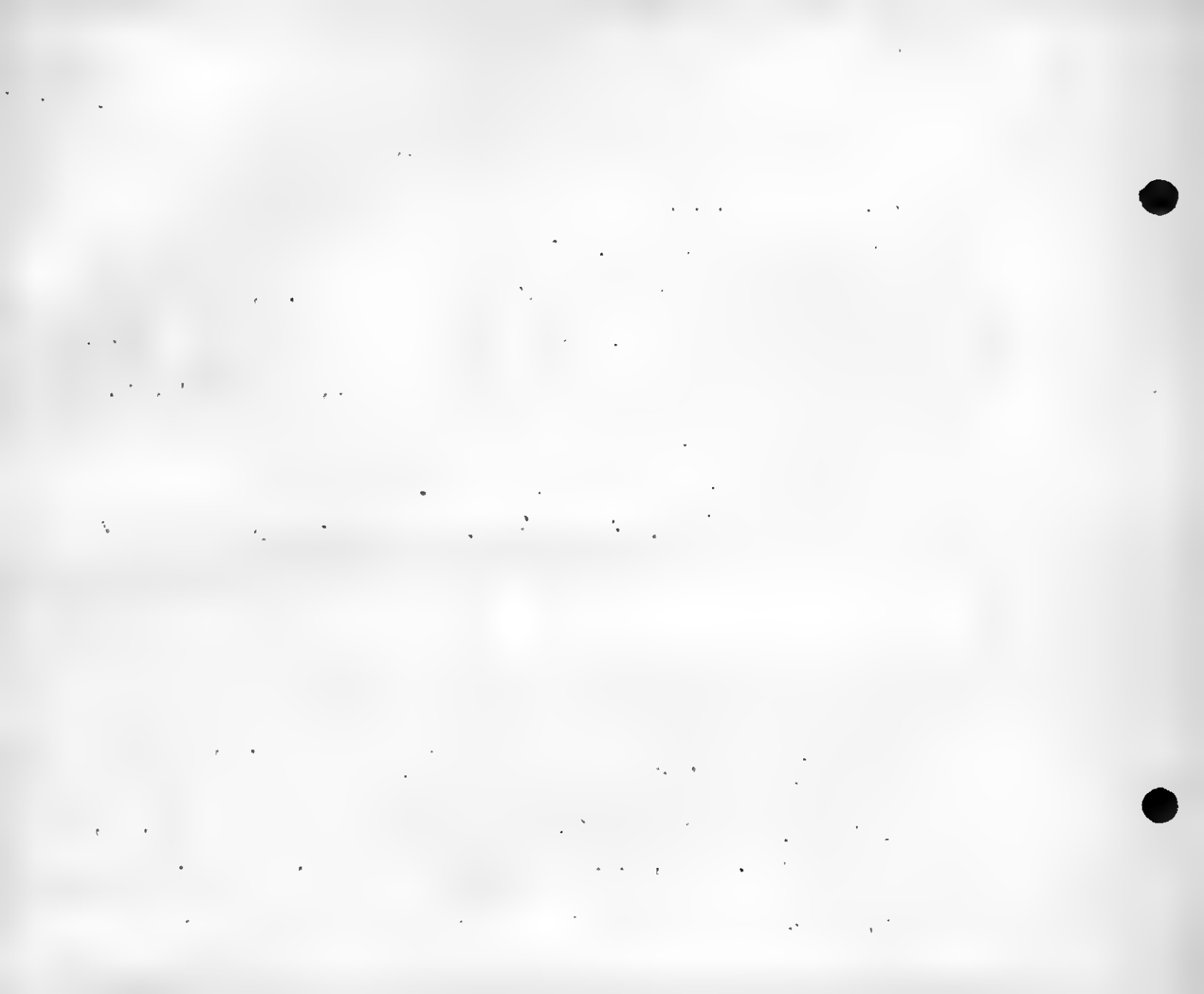
03525

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03519

1. DECEASED NAME (Type or print) Guy			First Guy Middle Leslie Last JONES			2a. DATE OF DEATH Month 3 Day 8 Year 69			2b. HOUR 10:10		
3 SEX Male			4. RACE Negro			5. DATE OF BIRTH April 15, 1965			6 AGE (In years last birthday) 3 YRS		
7a BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Owings Mills			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none			12b KIND OF BUSINESS OR INDUSTRY --		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Somerset			13c CITY OR TOWN Princess Anne			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Oscar Middle Benjamin Last Douglas			15 MOTHER'S MAIDEN NAME First Jenifer Middle Ann Last Jones			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO ---		
17 INFORMANT Rosewood Records, Owings Mills, Md. 21117			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 505.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration Gastric Contents & Mucous DUE TO, OR AS A CONSEQUENCE OF (c) Mucous from Chronic Sinusitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Termed Termed 6 Months			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 26, 1966 , to Mar. 8, 1969 , that (I) (we) last saw the deceased alive on Mar. 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (d) (d) view the body after death.											
22b SIGNATURE Richard A. Jones						DEGREE MD ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED Mar. 10, 1969		
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.						22e ADDRESS Owings Mills, Maryland. 21117					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 3/10/69			23c. NAME OF CEMETERY OR CREMATORY PRINCESS ANNE CEM			23d LOCATION (City or Town) (County) (State) PRINCESS ANNE Md.		
24. FUNERAL DIRECTOR E. Gray O. Stiller, Jr.			25a REC'D BY REGISTRAR Charles Judge			25b REGISTRAR'S SIGNATURE Charles Judge			DATE MAR 11 1969		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M. REV

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03526 CERTIFICATE OF DEATH 03520										
1. DECEASED-NAME (Type or print)			First Maisie		Middle C.		Last Jones		2a. DATE OF DEATH Month Day Year March 1, 1969	
3 SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 12, 1910			6. AGE (In years last birthday) 58 YRS.		2b. HOUR 2 15 PM	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Dundalk			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 400 Wise Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 400 Wise Avenue	
14. FATHER'S NAME First Middle Last Henry Yeager			15. MOTHER'S MAIDEN NAME First Middle Last Bertha			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) None				
16b. SOCIAL SECURITY NO None			17. INFORMANT (Husband) Mr. Russell F. Jones Sr.			Address Dundalk, Md. 400 Wise Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Osteo Sarcoma</u> 170.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diphtheria mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1966, to March 1, 1969, that (I) (we) last saw the deceased alive on Jan. 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ataollah Golpira</u>		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/3/69				
22a. PHYSICIAN'S NAME (Type) Ataollah Golpira		M.D.		22e. ADDRESS 1942 Cedar Lane, Dundalk, Md.				21222		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION (City or Town) (County) (State) Dorsey, Maryland				
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE MAR 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03521

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3 19 19 69		2b HOUR 4:55 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Dec. 29, 1948		6 AGE (in years last birthday) 20 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year March 19 19 69	
7a BIRTHPLACE (State or foreign country) Michigan		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto.					
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Medical Center		12a USUAL OCCUPATION (kind of work done during most of working life, even if retired) Labor		12b KIND OF BUSINESS OR INDUSTRY General Motors Co.					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto		13c CITY OR TOWN Loch Raven		13d INSIDE CITY, Y.N.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8113 Midhaven Rd.			
14 FATHER'S NAME First Middle Last Rayburn C. Jones		15. MOTHER'S M A D E N NAME First Middle Last Orene Leftwich									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (1 yes give war or dates of service) 213-52-2455		17 INFORMANT (Mother) Mrs. Orene Jones		ADDRESS Dundalk, Md. 8113 Midhaven Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Drowning DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year 3:35 PM 3 19 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of motorcycle lost control &							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street - water		21f LOCATION Street or R.F.D. No City or Town County Balto State 3360'S of Morgan Mill Rd. Loch Raven Drive							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		22b. DATE SIGNED 3/19/69		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/22/69		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.					
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a. REC'D BY REG-STRAR MAR 24 1969		25b REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be defoliated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

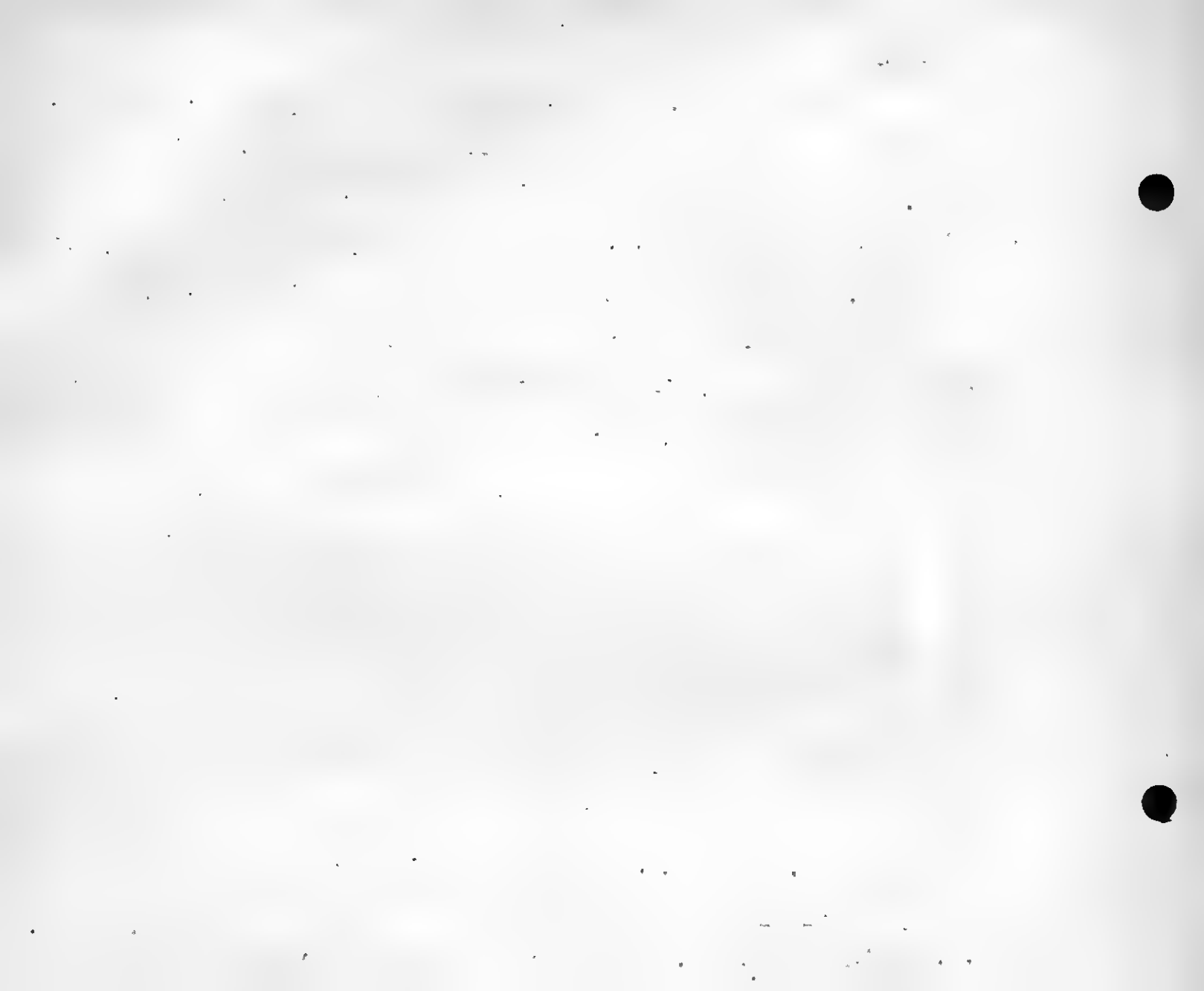
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03528

CERTIFICATE OF DEATH

03522

1. DECEASED NAME (Type or print) John W. Jordan			2a. DATE OF DEATH Month March Day 7 Year 1969			2b. HOUR 1:30 PM	
3 SEX M		4 RACE W		5. DATE OF BIRTH 2-24-1915		6 AGE (in years last birthday) 54 YRS.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 317 Warren Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales-Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Nursery	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b CITY OR TOWN Baltimore Cockeysville		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 317 Warren Road	
14. FATHER'S NAME First Middle Last John Henry Jordan			15 MOTHER'S MAIDEN NAME First Middle Last Marie Reihl				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 216-05-4408		17 INFORMANT Florence E. Jordan		Address Same	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AOR DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSION, AORTIC STENOSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-8-1968 to 3-4-1969 , that (I) two saw the deceased alive on 3-4-1969 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) two did (did not) view the body after death.							
22b. SIGNATURE MA		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3. 8 69			
22d. PHYSICIAN'S NAME (Type) Dr. Keith A. Mahley		22e. ADDRESS 2045 York Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-11-69		23c. NAME OF CEMETERY OR CREMATORY Fork Methodist		23d. LOCATION (City or Town) (County) (State) Fork Balto. Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Road		25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
30M REV. 1-68

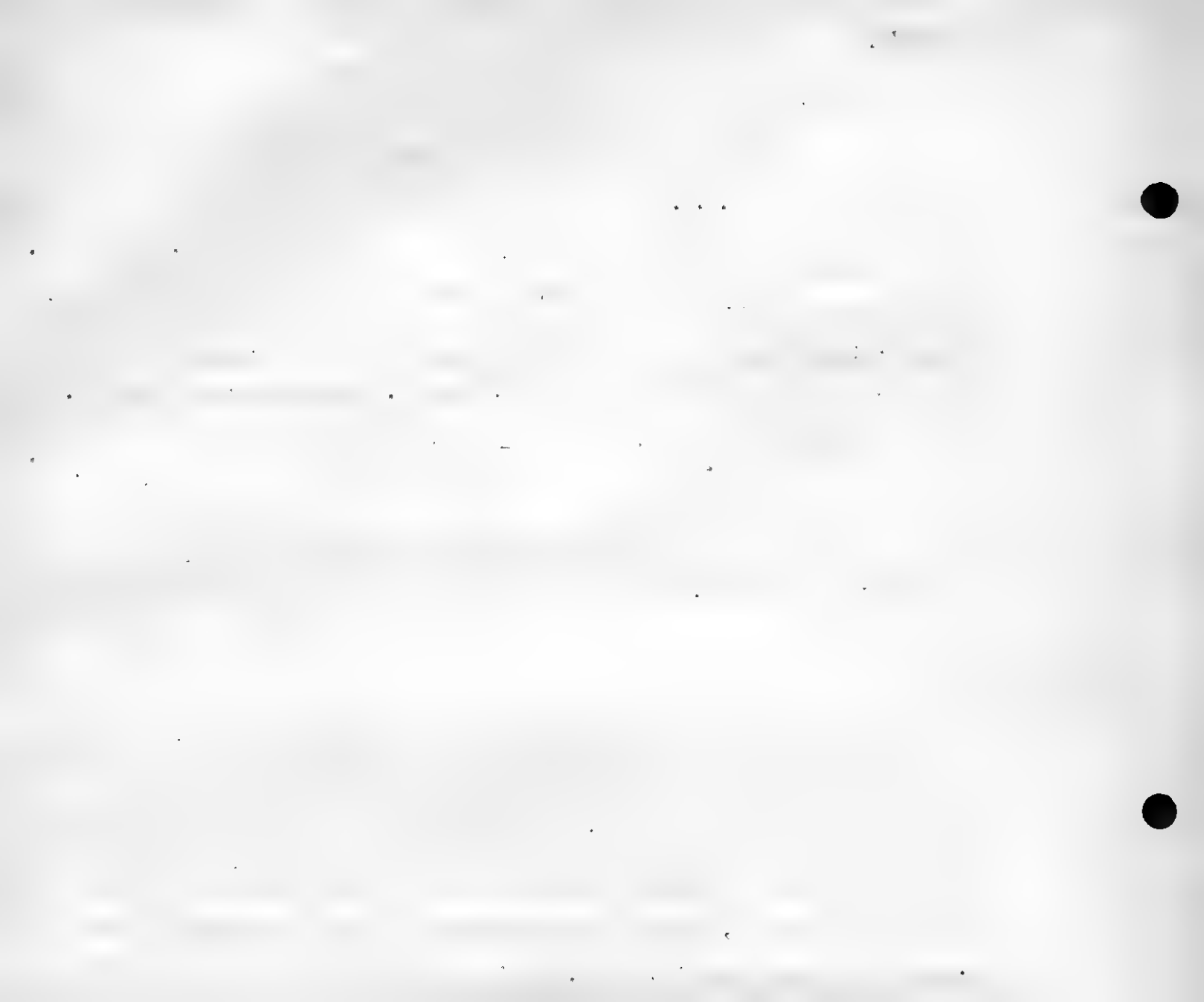
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03529		CERTIFICATE OF DEATH						03523			
1. DECEASED NAME (Type or print)			First Middle Last			2c. DATE OF DEATH			2b. HOUR		
MARGARET			KELLEY			March Month 29 Day 1969 Year			6:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
Female		White		1-17-1896 1897			45-72 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Delaware			USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph's Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland								YES <input type="checkbox"/> NO <input type="checkbox"/>		100 West Coldspring Lane	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
John E. Kelley						Mary J. Griffith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
No			212-10-6814		4301 Mass Ave N.W. Mrs Anne K Linsley Wash D.C.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis											
4359 DUE TO, OR AS A CONSEQUENCE OF (b) chronic brain syndrome											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) acute pyelonephritis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-12, 19 69, to 3-29, 19 69, that (I) (we) lost the deceased alive on 3-29, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. R. Radmanesh						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Dr. Ramazanali Radmanesh						22e. ADDRESS 7620 York Rd. Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		4/2/69		Woodlawn		Balt. Co. Md					
24. FUNERAL DIRECTOR Wm Cook-Brooks West Inc 6212 Balt. Nat. Pike Balt. Md 21228						25a. REC'D BY REGISTRAR DATE APR 3 1969		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03530										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03524									
Item 5 Filed 4/10 3/17/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First William					Middle E.					Last Klingelhofer					2a. DATE OF DEATH Month Day Year March 10, 1969					2b. HOUR P. 2:10 M				
3 SEX Male					4. RACE White					5. DATE OF BIRTH 5-13-1886 1885					6. AGE (In years last birthday) 83 YRS					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Baltimore					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Baltimore Md.														
10. CITY OR TOWN OF DEATH Towson					11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired					12b. KIND OF BUSINESS OR INDUSTRY Mt. Olivet Cem.														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Baltimore					13c. CITY OR TOWN Randallstown					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER Allen Rd., Randallstown, Md.									
14. FATHER'S NAME Adolph Klingelhofer					First Middle Last					15. MOTHER'S MAIDEN NAME Mary Wess					First Middle Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO					16b. SOCIAL SECURITY NO (If yes give year or dates of service) 213-05-8411A					17. INFORMANT Mrs. Helen M. Klingelhofer 308 Allen Rd.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bilateral broncho-pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>bilateral pyonephrosis</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (A) (this hospital) attended the deceased from <u>January 16, 1969</u> , to <u>March 10, 1969</u> , that (A) (we) last saw the deceased alive on <u>March 10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Reynaldo Orjuela-Gomez, M.D.</i>					DEGREE M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED March 10, 1969														
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.					22e. ADDRESS 7620 York Rd., Towson, Md. 21204																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE March 13, 69					23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery					23d. LOCATION (City or Town) (County) (State) Baltimore County Maryland														
24. FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Rd. 21133					ADDRESS					25a. REC'D BY REGISTRAR DATE MAR 13 1969					25b. REGISTRAR'S SIGNATURE <i>William A. Neeley</i>														



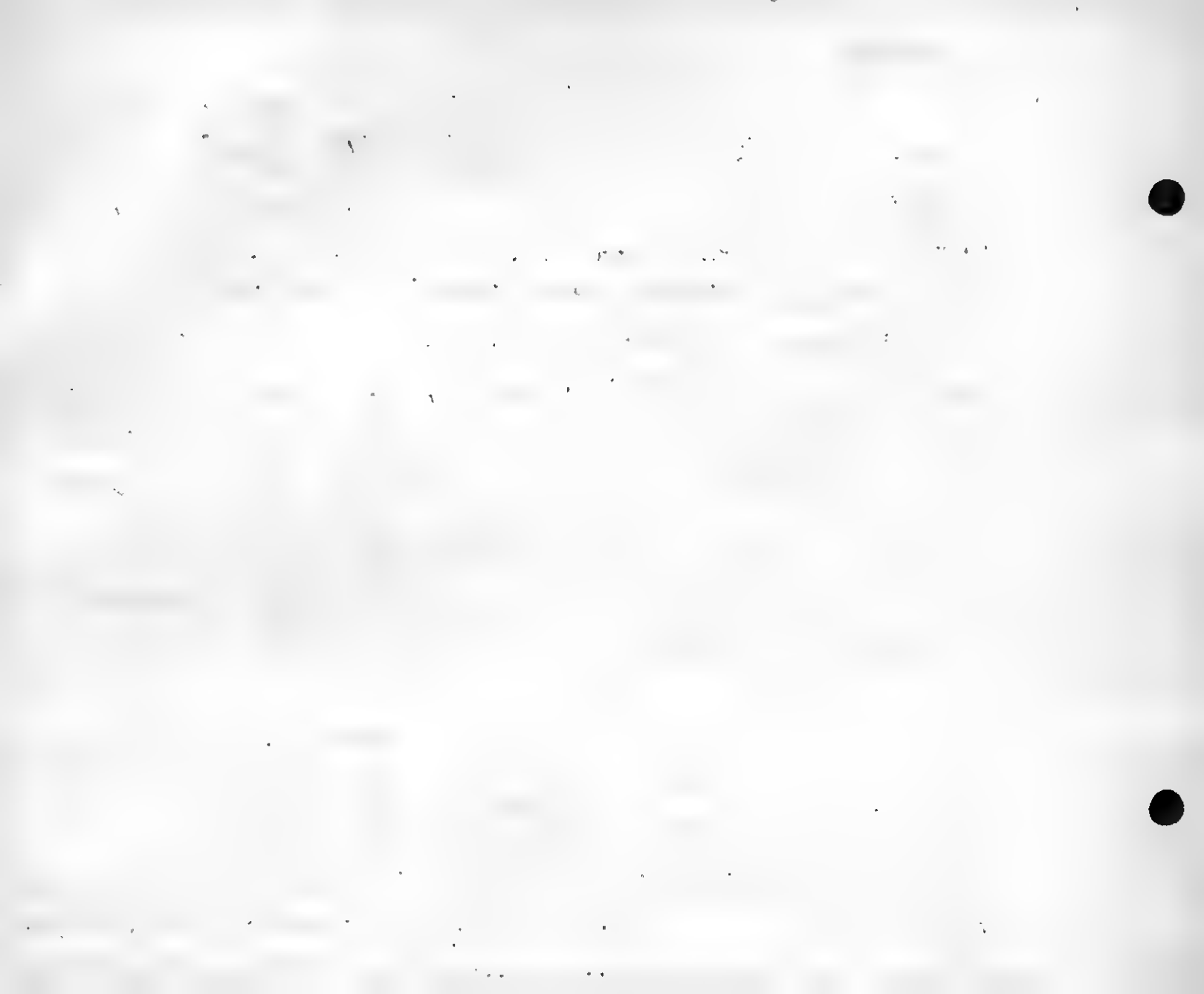
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03531

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
ROBERT				KRAMER	MAR 1 1969		12 45	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last bth)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
MALE	WHITE		4/30/10		58 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.	US				Baltimore County, Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Mount Wilson		Mt. Wilson St. Hosp.		INSURANCE				
3a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		3b. COUNTY		13c. CITY OR TOWN	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
MD		HARFORD		HAVERDEGRACE	NO	666 REVOLUTION ST		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
WILLIAM				KRAMER	CLARA			BERGER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO		218-05-9378		Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Emphysema, chronic, Obstructive</u>								10 YRS
518X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchiectasis</u>								10 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that he (this hospital) attended the deceased from <u>11/1</u> , 19 <u>68</u> , to <u>1 Mar</u> , 19 <u>69</u> , that he (we) last saw the deceased alive on <u>1 Mar</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) and view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22e. ADDRESS				
W. Newcomer				Mount Wilson, Maryland				
22d. PHYSICIAN'S NAME (Type)		22f. ADDRESS		22g. REC'D BY REGISTRAR				
William Newcomer, M.D.				MAR 4 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3/5/69		Methodist Cemetery		Solomons Island, Maryland		
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Witzke, 4101 Edmondson Ave., Balto., Md				MAR 4 1969		Charles Judge		

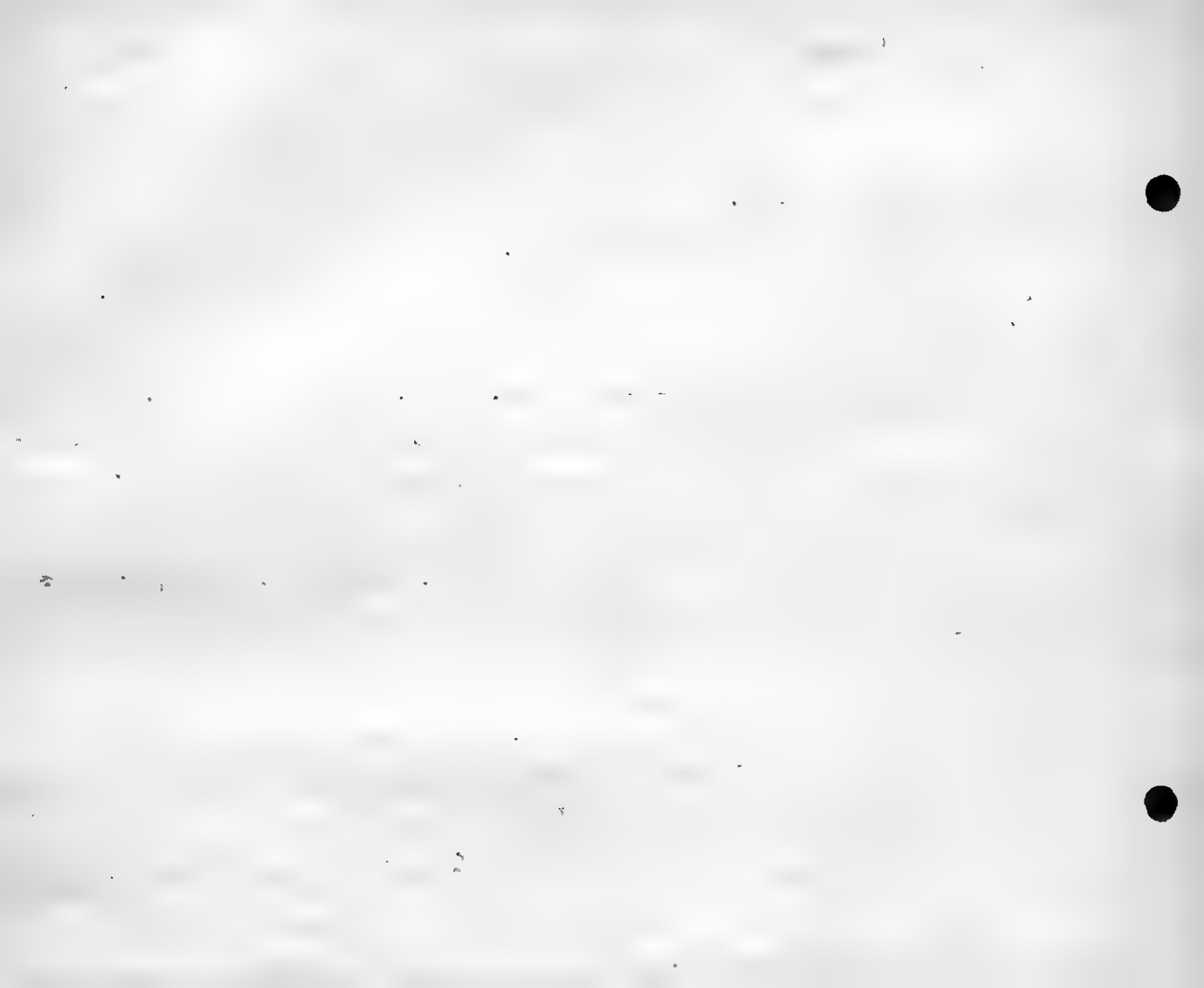


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 CALLED ASST MED EXAM DR. SPITZ RE RELEASED BODY

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
03532									
03526									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
John		Kraus		March		16		1969	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7b. HOUR	
Male		White		11/30/ 1889		79		10:25 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. IF UNDER 1 YEAR	
Balto, Md		U.S.A.				Baltimore		MONTHS DAYS HOURS MIN	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		311 Bloomsbury Ave.		retired		plumbing			
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Balto.		Catonsville				311 Bloomsbury Ave.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Henry Kraus								Mary	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
yes		220-30-7208		Mrs. John W. Kraus		23 Maple Ave.		21228	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CORONARY THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		MINUTES	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		CARCINOMA OF RT LUNG		5 Mos			
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		ARTERIOSCLEROSIS; PERNICIOUS ANEMIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from APR 3, 1962, to MAR 16, 1969, that (I) (we) last saw the deceased alive on JAN 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. XRAY TREATMENT UNIV HOSP 3/14/69		22b. SIGNATURE John W. Snyder MD		22c. DATE SIGNED 3/17/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
John W. Snyder MD		6348 FREDERICK RD.		21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		3/19/69		Lorraine Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Witzke, 4101 Edmondson Ave., 21229				DATE MAR 18 1969		J. Charles Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

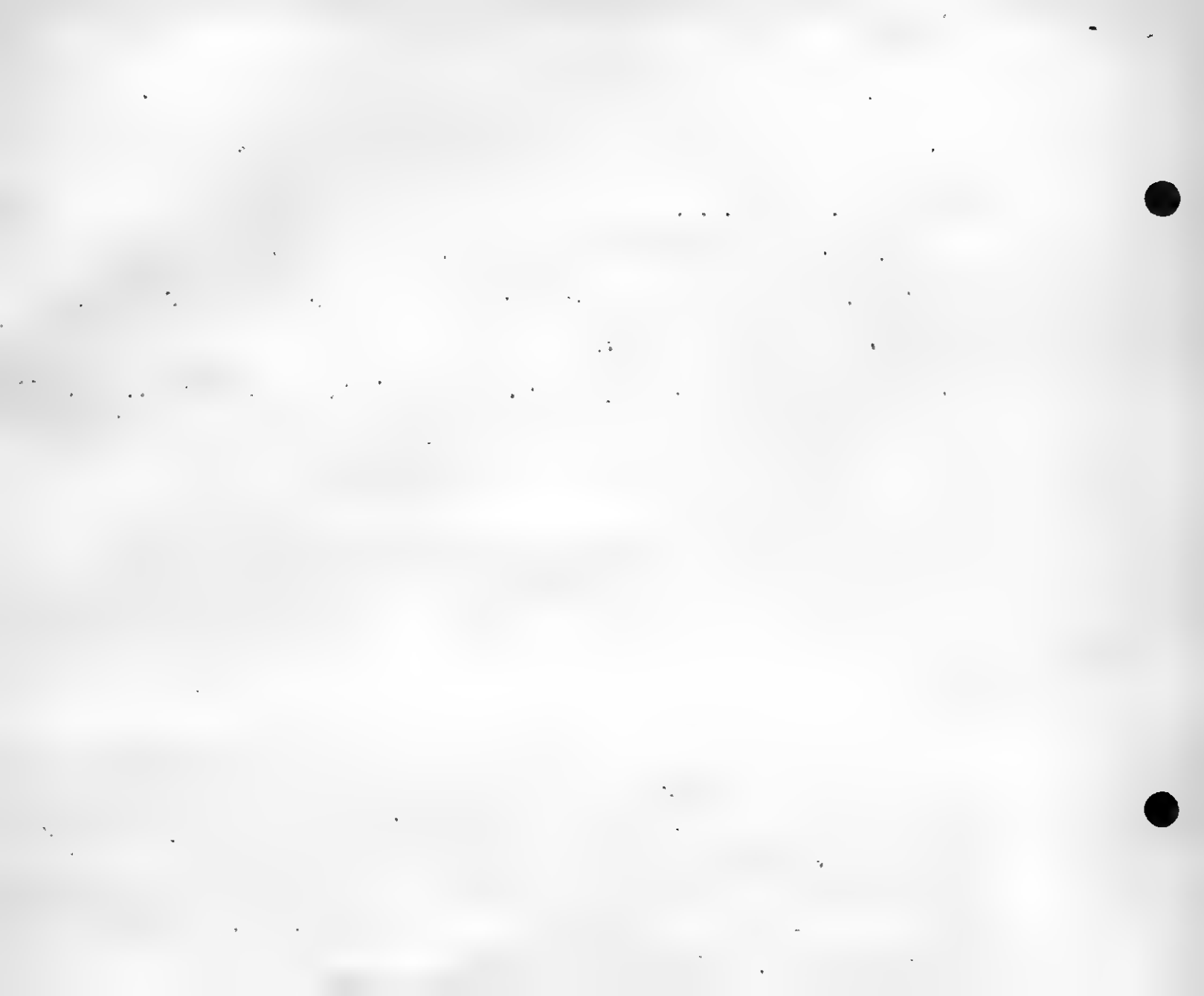
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03533

CERTIFICATE OF DEATH

03527

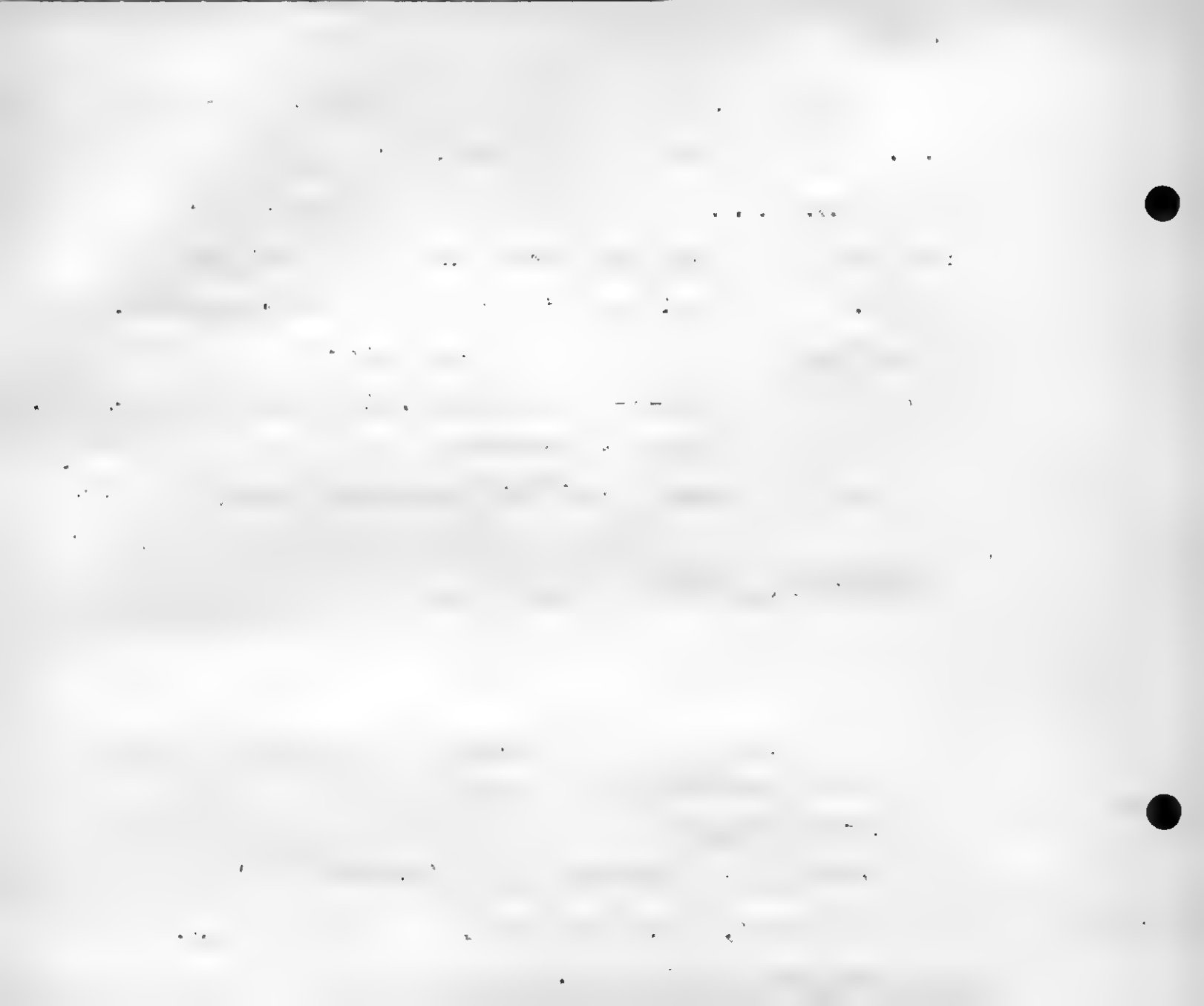
1. DECEASED-NAME (Type or print) <i>Last</i> <i>First</i> <i>Middle</i> <i>KRAVITZ, Celia</i>		2a. DATE OF DEATH Month <i>3</i> Day <i>27</i> Year <i>69</i>		2b. HOUR <i>11:45</i> M	
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>7-8-01</i>	6. AGE (In years last birthday) <i>67</i> XXXX YRS	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>BALTIMORE</i>		Md
10. CITY OR TOWN OF DEATH <i>PIKESVILLE</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MILFORD MANOR NURSING HOME</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>BALTIMORE</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	3e. STREET AND NUMBER <i>4026 GREENSPRING AVENUE</i>	
14. FATHER'S NAME First <i>JACOB</i> Middle <i>LEVITON</i> Last <i>MARY</i>	15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>LEVITON</i> Last <i>1</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. <i>213-05-5620</i>		17. INFORMANT Address <i>MR. SIMON LEVITON, 6512 EBERLE DR., APT. 203</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <i>4-4-1</i> IMMEDIATE CAUSE (a) <i>Cerebral Vascular Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cerebral Anterior Artery</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Anterior Artery</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>6 mo</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 19 <i>68</i> , to <i>Mar 27</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Mar 26</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Irvin Sauber</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>3/27/69</i>		22d. PHYSICIAN'S NAME (Type) <i>IRVIN SAUBER</i>	
22e. ADDRESS <i>PARK HEIGHTS AVENUE</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>3-30-69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>BNAI ISRAEL</i>	23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE, MARYLAND</i>		
24. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>	25a. REC'D BY REGISTRAR DATE <i>APR 1 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Jones</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>03534</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 5 Film 410 3/17/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>03528</div>											
1. DECEASED-NAME (Type or print) Anna Bowen Kuhn						2a. DATE OF DEATH MARCH Month 10 Day 69 Year			2b. HOUR 2 P. M.		
3. SEX F. M.		4. RACE White		5. DATE OF BIRTH Jan 5, 1891			6. AGE (in years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New York N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County			Md		
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.			13b. COUNTY Baltimore			13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 201 Sunnydale Way.	
14. FATHER'S NAME First Middle Last Patrick Bowen				15. MOTHER'S MAIDEN NAME First Middle Last Mary Sullivan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 158-20-2995		17. INFORMANT Address Margaret C. Littlefield 201 Sunnydale Way.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease with Uremia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertrophic Arthritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to 3/10 , 19 69 , that (I) (we) last saw the deceased alive on 3/9 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Martin E. Strobel						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/10/69			
22d. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL						22e. ADDRESS 59 HANOVER, RD. REISTERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 13, 69		23c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery				23d. LOCATION (City or Town) (County) (State) Lyndhearth N.J.			
24. FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Rd. 21133						25a. RECEIVED BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-15. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03535		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						03529	
1 DECEASED NAME (Type or Print) William		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Mar 3 1969	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Jan 28, 1891		6 AGE (In years and birthday) 78 YRS		2c DATE PRONOUNCED DEAD Month Mar Day 3 Year 1969	
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Co.		Md	
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7414 Old Battle Grove Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Meat Packer		12b KIND OF BUSINESS OR INDUSTRY USA			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7414 Old Battle Grove Rd.	
14. FATHER'S NAME First Middle Last Christian F. Kurrle				15. MOTHER'S MAIDEN NAME First Middle Last Julia Rauber					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 219 05 83394		17 INFORMANT Elmer B. Kurrle		ADDRESS Mohr Rd.		Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-Sclerotic and Hypertensive DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } (b) Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) -----									
19a DATE OF OPERATION -----				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? -----				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) -----					
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) -----		21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Melvin Davis		EXAMINER'S NAME (Type) Melvin Davis		M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 3/5/69	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE March 6, 1969		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR Dippel Brothers Inc. 7110 Belair Rd.				25a REC'D BY REGISTRAR DATE MAR 6 1969		25b REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

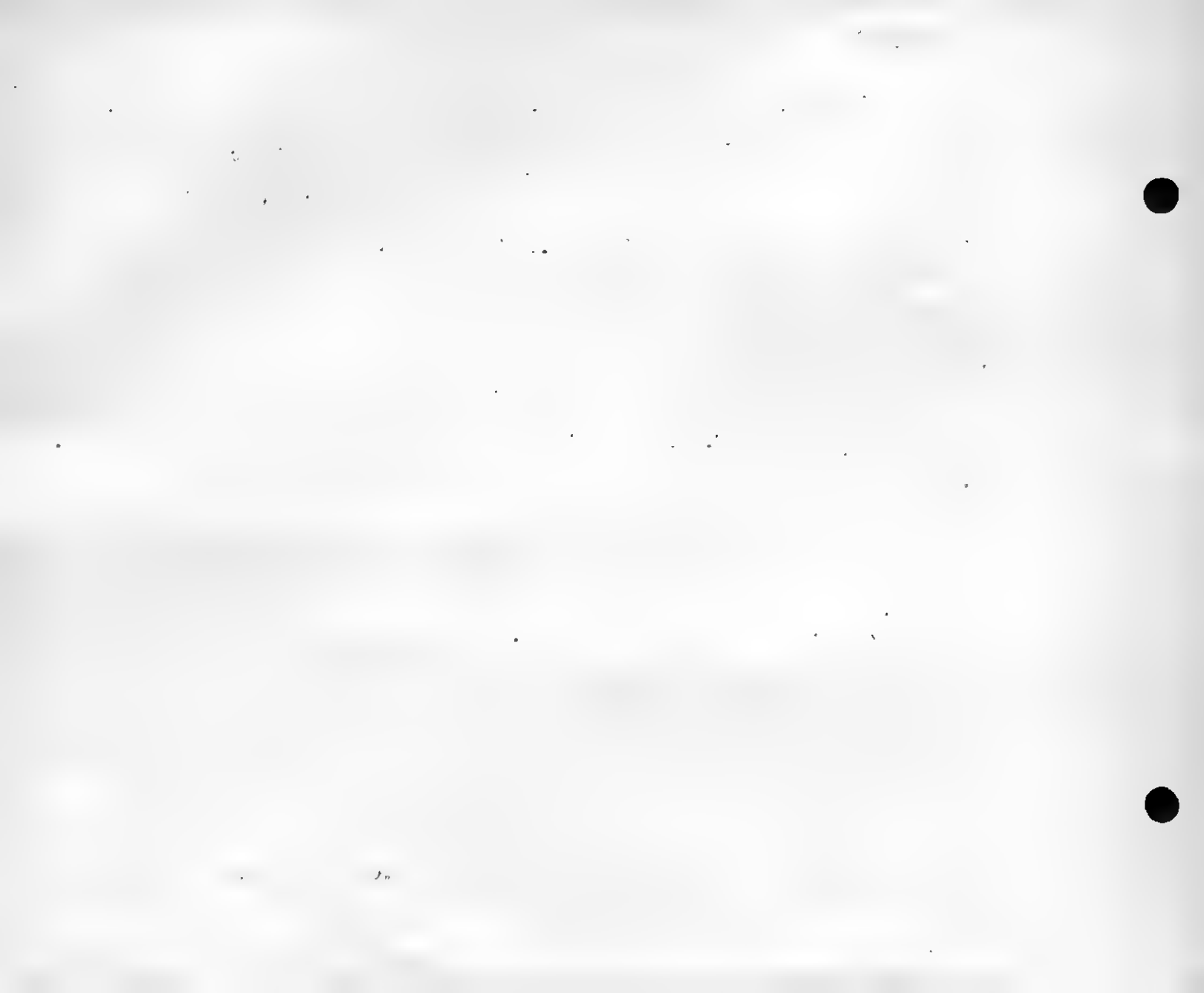
03530

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Liberty Irene Kyriakou						Month	Day	Year	8:15A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		9-4-20		48 YRS.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U. S. A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Med. Center			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Pa.			✓			McKeesport		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1918 Bailie Ave.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
James					Fleczanis	Helen					Matsouris
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
No			-			Charles Kyriakou			1918 Bailie Ave., McKeesport, Pa.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Polyarteritis</u>											
4460 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I (this hospital) attended the deceased from Feb. 8, 1969, to Mar. 2, 1969, that (I) (we) last saw the deceased alive on March 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
John E. Adams										Mar. 3, 1969	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
John E. Adams, M.D.						Greater Balto. Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		3/5/69		Greek Orthodox Cem.			Baltimore, Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nicholas T. Matthews						DATE MAR 7 1969		Charles Judge			
3021 Eastern Ave., Baltimore, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
035337											
Item 23 Filed 10/3/20/69 kk											
CERTIFICATE OF DEATH											
03531											
1. DECEASED-NAME (Type or print) ADOLPH I. KYTE						2a. DATE OF DEATH Month 3 Day 11 Year 69			2b. HOUR IN 12:32		
3 SEX MALE		4. RACE CAUC		5. DATE OF BIRTH 1-29-14		6 AGE (In years last birthday) 55 YRS		7 UNDER 1 YEAR MONTHS 5 DAYS 2		IF UNDER 24 HRS HOURS 12 MIN 32	
7a BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE CO.					
10 CITY OR TOWN OF DEATH TOWSON				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GTR. BALTO. MED. CENTER				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supv. 1		12b KIND OF BUSINESS OR INDUSTRY Supv. 1	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.				13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7862 St. Monica Drive	
14. FATHER'S NAME First Middle Last James Kyte				15. MOTHER'S MAIDEN NAME First Middle Last Edna Hammer							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO. 21-07-8484		17 INFORMANT Address Mrs. Florence Kyte, 7862 St. Monica Drive					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SMALL INTESTINAL GANGRENE 5609 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 MO.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION 1-22-69 3-10-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL INTESTINAL OBST.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/18, 1969 , to 3/11, 1969 , that (I) (we) last saw the deceased alive on 3/10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bahram Eslami						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/11/69			
22d. PHYSICIAN'S NAME (Type) BAHRAM ESLAMI						22e. ADDRESS 6701 N. CHARLES ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Porter, Md.					
24. FUNERAL DIRECTOR Ulrich Funeral Home, Baltimore, Md.						25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE Richard Under			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03538										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03532									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First PAUL Middle E. Last LAFERTY										3 Month 13 Day 69 Year										7:40 M									
3 SEX Male										4 RACE Cau.										5. DATE OF BIRTH April 29, 1900									
7a BIRTHPLACE (State or foreign country) Maryland										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10 CITY OR TOWN OF DEATH Baltimore, Md.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC										9. COUNTY OF DEATH Baltimore, Md									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland										13b COUNTY Baltimore										13c CITY OR TOWN Lutherville									
13d INSIDE CITY, JIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e STREET AND NUMBER 207 Welford Road										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civil Engineer									
14 FATHER'S NAME First John Middle Edward Last Laferty										15. MOTHER'S MAIDEN NAME First Anna Middle Genso Last										12b KIND OF BUSINESS OR INDUSTRY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No										16b SOCIAL SECURITY NO 214-40-4134										17 INFORMANT Mrs. Gladys S. Laferty Address Same as #13 E									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage																													
5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding esophageal varices and peptic ulcers																													
DUE TO, OR AS A CONSEQUENCE OF (c) Laennec's cirrhosis of liver																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
Recurrent pituitary adenoma																													
19a. DATE OF OPERATION 3/13/69										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastro-intestinal hemorrhage										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 3/12, 1969, to 3/13, 1969, that (I) (we) last saw the deceased alive on 3/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE [Signature]										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 3/14/69									
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.										22e. ADDRESS Greater Baltimore Medical Center																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 3-17-69										23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery									
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc.										ADDRESS Towson, Md. 21204										23d. LOCATION (City or Town) (County) (State) Cockeysville Maryland									
25a. REC'D BY REGISTRAR 17 1969										25b. REGISTRAR'S SIGNATURE [Signature]																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03539

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03533

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Charles			M		Lam	March 25 69				
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male		White		Sept. 12, 1903		65 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Virginia			U.S.A.				Baltimore			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Parkville			8420 Oakleigh Rd			Foreman Nursery				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Parkville				8420 Oakleigh Rd	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Last
John			R		Lam	Mariam			V	Peregory
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address		
No			215-05-6683		Mrs Marie M Lam			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary of the left lung - atherosclerosis</u>										15 months
1621 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County
22a. I certify that (I) (this hospital) attended the deceased from 1.4, 1968, to 3.25, 1969, that (I) (we) last saw the deceased alive on 3.15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph Skloven M.D.</u>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3.27.69
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Joseph Skloven M.D.						7122 Harford Rd Baltimore, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)
Burial		3/28/69		Parkwood			Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Leonard J Ruck Inc. Baltimore, Maryland						APR 1 1969		<u>Joseph Skloven</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03540				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03534			
Item #5, Film G110 3/24/69 km				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last RICHARD M. LARRICK SR.				2a. DATE OF DEATH Month Day Year MARCH 16 1969				2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH 1906 May 17, 1906		6. AGE (In years lost birthday) 62 YRS		F UNDER YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) Middletown		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 24 N. Symington Ave		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) auditor		12b. KIND OF BUSINESS OR INDUSTRY Acct.					
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 N. Symington Ave.			
14. FATHER'S NAME First Middle Last Richard R. Larrick				15. MOTHER'S MAIDEN NAME First Middle Last Mary Dunbar							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none		17. INFORMANT Address 220-18-8446 Mrs Agnes O'Leary Larrick 24 N. Symington Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Abdominal distention - Electrolyte imbalance											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 3/16, 1969, that (I) (we) saw the deceased alive on 3/12/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. (I) (we) (saw) (saw no)											
22b. SIGNATURE Daniel Nolan				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/18/69			
22d. PHYSICIAN'S NAME (Type) J. J. NOLAN				22e. ADDRESS Baltimore Md 21229							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 19 1969		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Howard Cty, Maryland					
24. FUNERAL DIRECTOR Sterling Funeral Exch 736 Edmondson Ave. Catonsville, Md. 21225				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE Richard J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03541

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03535
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SOL SALLY LAUFER		First Middle Last		2a. DATE OF DEATH Month 3 Day 3 Year 69		2b. HOUR 2:45 M	
3 SEX M.		4. RACE W		5. DATE OF BIRTH 3-6-96		6 AGE (In years last birthday) 72 YRS.	
7a BIRTHPLACE (State or foreign country) Germany		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Co Gen Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b COUNTY Balto		13c CITY OR TOWN Randallstown		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e STREET AND NUMBER 4 Albess Ct.		14 FATHER'S NAME First Middle Last Hermann Laufer		15 MOTHER'S MAIDEN NAME First Middle Last Hulda Cohn			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO 067-16-204/A		17 INFORMANT Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Crisis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive ASCVD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 3 hrs. years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Pulmonary Edema							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-24-1969 , to 3-3-1969 , that (I) (we) last saw the deceased alive on 3-3-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Cesar Valle Cervero				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 3-3-69	
22d PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO				22e ADDRESS 8629 Liberty Rd			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 3/5/69		23c NAME OF CEMETERY OR CREMATORY Cedar Park		23d LOCATION (City or Town) (County) (State) Westfield Baltimore New Jersey	
24 FUNERAL DIRECTOR Sylvan L. Lewis				ADDRESS Lewis & Sons Inc.		25a REC'D BY REGISTRAR MAR 6 1969	
				25b REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03542

CERTIFICATE OF DEATH

03536

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Myra		C.		Lauterbach	March Month 3 Day 1969 Year		7:25 AM		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR		
Female	white		8-9-1893		75 YRS.		IF UNDER 24 HRS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore, Md.		U.S.A.				Baltimore County Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INST. T. T. ON (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		St. Joseph Hospital		Homemaker		---			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE CITY LIM. 159		13e. STREET AND NUMBER	
Maryland		Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		218 Cherrydell Rd. 21228	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
William E. Chapman		Lucy Childress							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		214-16-6670A		H- Maynard F. Lauterbach		218 Cherrydell Rd. Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis and congestive heart failure									
4124 DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from 2-22-69, 19 to 3-3-1969, that (I) (we) last saw the deceased alive on 3-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Beatriz P. Dizon								3-3-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Beatriz P. Dizon				7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/6/69		Woodlawn Cemetery		Baltimore, Maryland.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
736 Edmondson Ave.		Catonsville, Md. 21228		MAR 6 1969		Charles J. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03543		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03537	
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH 3 Month 6 Day 1969 Year	
Ida					Lawrence	2b HOUR M	
3. SEX Female	4. RACE Cau		5. DATE OF BIRTH 7-3-1881		6. AGE (In years last birthday) 87 YRS		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Chase, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Middle River		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ivy Hall Nursing		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cashier		12b KIND OF BUSINESS OR INDUSTRY Austin Store	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Chase		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				13e STREET AND NUMBER Rt 11 Box 24D 21220			
14. FATHER'S NAME First Middle Last James Carback			15. MOTHER'S MAIDEN NAME First Middle Last Frances Sterling				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? No (yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Christian C. Lawrence Rt 11 Box 24D 21220		
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
20c ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1965, to March 6, 1969, that (I) (we) last saw the deceased alive on March 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>G. M. Baumgardner</u>		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 3-7-69	
22d PHYSICIAN'S NAME (Type) G. M. BAUMGARDNER		22e ADDRESS Balto 21237					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3-10-1969		23d NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d LOCATION (City or Town) (County) (State) Chase Baltimore Md	
24 FUNERAL DIRECTOR Laswahn Funeral Home 7401 Belair Road 21236				25a REC'D BY REGISTRAR MAR 12 1969		25b REGISTRAR'S SIGNATURE [Signature]	

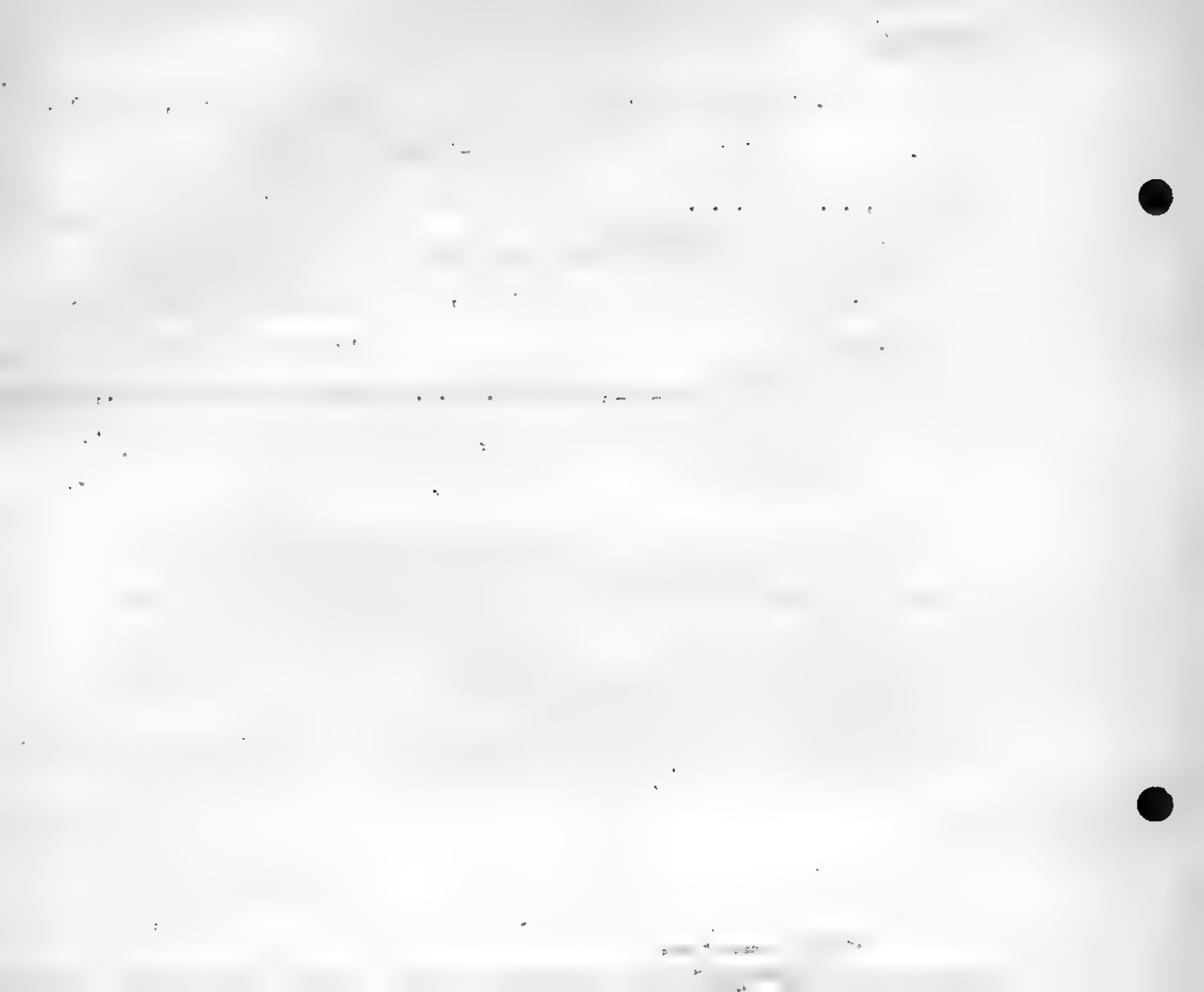
03544

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOSEPHINE FOSTER LEICH					MARCH 18th, 1969		10:55 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-30-1888		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
LUTHERVILLE		COLLEGE MANOR NURSING HOME		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Indiana				Evansville,				928 Bayard Park Drive,	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
JOHN H. FOSTER					JOSEPHINE PIPER FOSTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		311-09-6514 D		Mrs. Geo. V. Parkhurst,		4513 Roland Ave., Baltimore			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>									Days Years
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 18, 1967</u> to <u>Mar 18, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
RK Gundry MD		3-18-69		RK GUNDY		24 W University Pkwy - 21218			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		March 19, 1969		Loudon Park Crematory		Baltimore, Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Sterling Funeral Estate		MAR 20 1969		Julian J. Young					
736 Edmondson Ave.									
Baltimore, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03545										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03539									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First			Middle			Last				Month			Day			Year				M			M						
Dora			Lillian			Leutner				03			14			69													
3. SEX			4. RACE			5. DATE OF BIRTH				6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS													
Female			white			08/31/91				77			MONTHS			DAYS			HOURS			MIN							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. COUNTY OF DEATH																			
Baltimore			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore																			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY																			
Baltimore			Balto. Cnty. Gen.			At Home																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN				13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER																
Maryland			Balto			Balto							2107 Southland Road #7																
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First			Middle			Last			First			Middle			Last														
William			Kasten						Julia						Houck														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT																							
NO			None			Arthur G. Leutner - 2107 Southland Road																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>																		<u>1/2 hr</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Interoskeletal Cr. disease</u>																													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>unintentional, general</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED															20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
			HOUR A.M. Month Day Year																										
			P.M. 19																										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.			City or Town			County			State											
22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>59</u> , to <u>3/14</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE																		22c. DATE SIGNED											
<u>Arthur G. Leutner</u>																		<u>3/14/69</u>											
22d. PHYSICIAN'S NAME (Type)																		22e. ADDRESS											
																		<u>6416 W. Wisc. Ave. Balto</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)														
Burial			3-17-69			Lorraine Cemetery			Baltimore, Maryland																				
24. FUNERAL DIRECTOR																		25a. READ BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Armacost Funeral Chapel-4600 Liberty Hts.																		MAR 18 1969						<u>age</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03546

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03540

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Dora</u>			First Middle Last			2a. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1969</u>			2b. HOUR <u>8:30 P.M.</u>								
3 SEX <u>Female</u>			4. RACE <u>White</u>			5. DATE OF BIRTH <u>[REDACTED]</u>			6 AGE (In years last birthday) <u>94</u>			F UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <u>Russia</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <u>Baltimore</u> Md.								
10. CITY OR TOWN OF DEATH <u>Baltimore</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Milford Manor Nursing Home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>md</u>			13b. COUNTY <u>Baltimore</u>			13c. CITY OR TOWN <u>Baltimore</u>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <u>6112 Gist Ave</u>					
14. FATHER'S NAME <u>[REDACTED] JONAH</u>			First Middle Last			15 MOTHER'S MAIDEN NAME <u>Ida</u>			First Middle Last			?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>no</u>			(If yes give war or dates of service)			16b SOCIAL SECURITY NO. <u>220-44-7503T</u>			17. INFORMANT <u>Jacob Levin</u>			Address <u>304 S. Beechfield Ave.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Pneumonia</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <u>436X</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)																	
<u>Pulmonary Fibrosis; Generalized arteriosclerotic Cardiovascular Disease</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>67</u> , to <u>Mar.</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Marvin M. Glazer, M.D.</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>3/21/69</u>								
22d. PHYSICIAN'S NAME (Type)			<u>MARVIN M. GLAZER</u>			22e. ADDRESS <u>6007 Park Heights Ave.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>3-23-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>			23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>								
24 FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>			ADDRESS			25a. REC'D BY REGISTRAR <u>MAR 26 1969</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03547

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03541

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First SAMUEL	Middle NUN	Last LEVY	2a. DATE OF DEATH Month 3 Day 1 Year 69		2b. HOUR 5A
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 4. 86		6. AGE (In years last birthday) 22 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) BALTO. MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO. COUNTY		Md.	
10. CITY OR TOWN OF DEATH BALTO. RANDALSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO COUNTY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TAILOR		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6962 MILBROOK PK., APT. 1 D			
14. FATHER'S NAME First MORRIS		Middle LEVY	15. MOTHER'S MAIDEN NAME First RACHEL		Last ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT MR. MERRILL LEVY, 5906 EASTCLIFF DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIO SCLEROTIC HEART DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-16, 1969, to 2-1, 1969, that (I) (we) lost saw the deceased alive on 3/1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stanley Rosen MD				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1 3 69	
22d. PHYSICIAN'S NAME (Type) STANLEY ROSEN MD				22e. ADDRESS BALTO COUNTY GENERAL HOSP.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-2-69		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REGISTERAR MAR 5 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>03548</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03542</div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
CALVERT			C. LEWIS			<input checked="" type="checkbox"/> Month Day Year 3/19 1969		M	
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	10/16/98	70 YRS				Month Day Year March 19, 1969		2:00 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Nev.		USA		BALTIMORE				PM	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital			Ret.		B. Steel Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.			Baltimore					13e. STREET AND NUMBER	
								9408 Old Harford Rd.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Yes. WWI						Hospital records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town or county)		March 20, 1969	
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/22/69		Parkwood Cem.		Balto Co. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE		
C.F. EVANS & SON 8802 Harford road					MAR 24 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for burial papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (11)
304 REV 1-64

03549

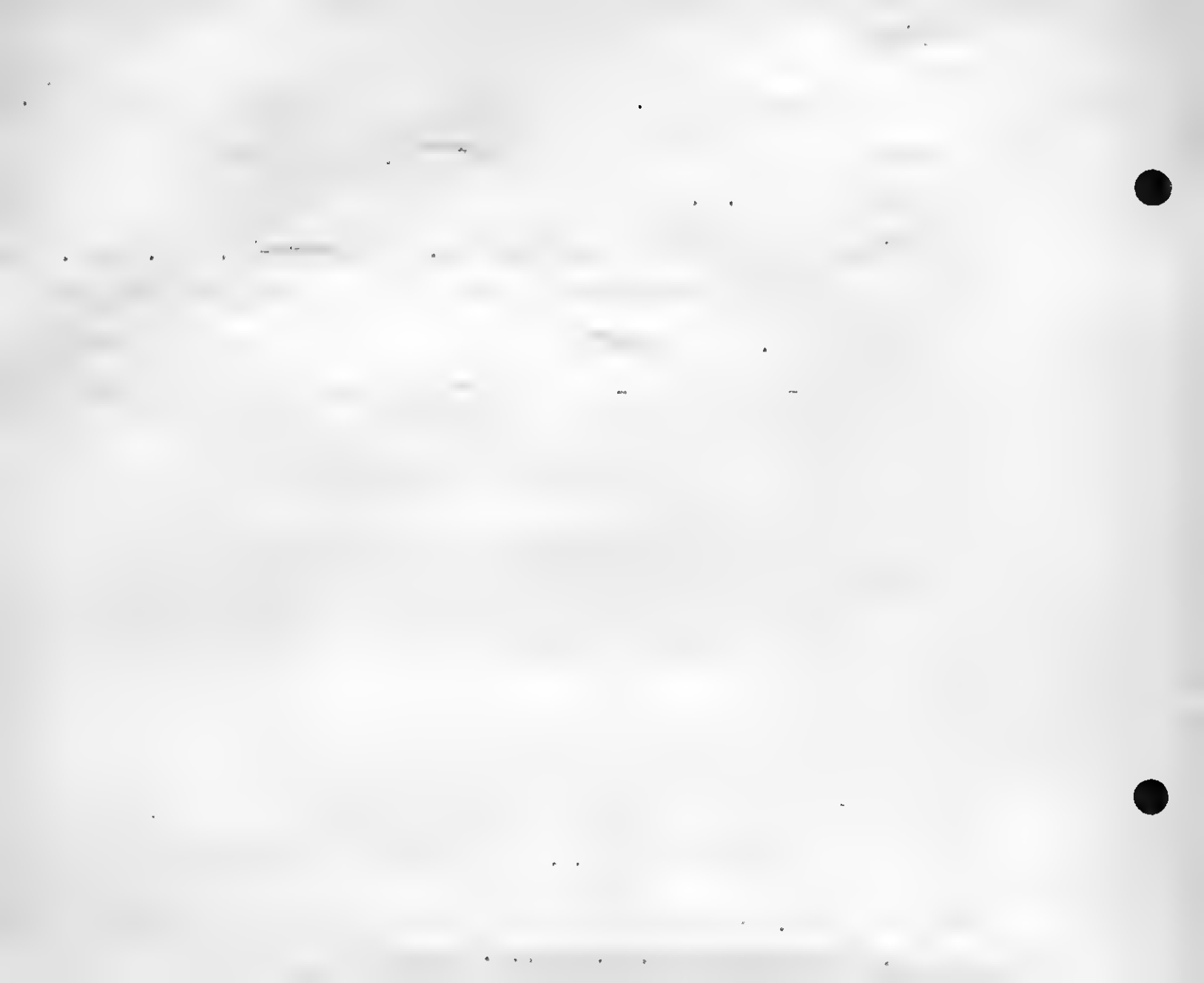
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03543

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR- MIN	
Dessie		M.		Lewis	March 24, 1969		4:25 a.m.	
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN
Female	White		April 19, 1894		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Georgia		U. S.				Baltimore Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USLA. OCCUPAT ON (Kind of work done during most of work not if even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		Spring Grove State Hosp.		Saleslady - W. & L. Dept. Store				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Prince Georges Suitland				5308 Shady Side Avenue		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
John T. Jones					Anna America Franklin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address		
No						Records--Spring Grove State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure								
4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Urinary tract infection with bacteremia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 9/28/67, 19 to 3-24-69, 1969, that (I) (we) last saw the deceased alive on 3-24-69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.								
22b. SIGNATURE		Dionidis L. Pirovolidis				22c. DATE SIGNED		3-24-69
22d. PHYSICIAN'S NAME (Type)		Dionidis Pirovolidis, M.D.			22e. ADDRESS		Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Mar. 26, 1969		Cedar Hill Cemetery		Suitland, Maryland		
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REG-STRAR		25b. REGISTRAR'S SIGNATURE	
Lee Fun. Home-300 4th St. NE, Wash., D.C.					MAR 26 1969		Michaela Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
30M REV 7-78

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03550		CERTIFICATE OF DEATH				03544			
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P M
Dorothea Lindsay						March 29 1969			7.45 P
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/3/1917		6. AGE (In years last birthday) 51 YRS		F UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.			
10. CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney-Towson Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Sparks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Upper Glencoe Rd.	
14. FATHER'S NAME First Middle Last Van Rensselaer Norman				15. MOTHER'S MAIDEN NAME First Middle Last Nellie Escott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 214-01-6056		17. INFORMANT Dulaney-Towson Nursing 111 West Rd, 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Multiple sclerosis</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF <u>Broncho pneumonia</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 26, 1969</u> to _____, 19____, that (I) (we) last saw the deceased alive on <u>March 29, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jamshid Hamed</u>		22c. DATE SIGNED 3/31/69		22d. PHYSICIAN'S NAME (Type) Dr. Jamshid Hamed		22e. ADDRESS 204-E 20PPA Rd Towson			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-2-1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204				25a. REC'D BY REGISTRAR APR 2 1969		25b. REGISTRAR'S SIGNATURE <u>Blanca Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03551

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03545

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
LILLIAN GRACE LINK					March 1, 1969		2:50 M	
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (n years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		July 28, 1885		83 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	U.S.A.				Baltimore		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Catonsville		Summit Nursing Home		Housewife				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland				Morrell Park				2808 Herkimer Street
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
William H. Booth					Martha A. Rawlings			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT Address				
		217-54-1739		Mr. Rudolph Link, 2808 Herkimer St. 21230				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u>								2 days
4124 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) (b) <u>Arteriosclerotic CVD, generalized,</u>								
stating the underlying cause (c) <u>with right hemiplegia</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or RFD No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>68</u> , to <u>3/1</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>2/28</u> , 19 <u>69</u> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED						
<u>Herbert J. Levickas</u>		3/3/69						
22d PHYSICIAN'S NAME (Type)		Dr. Herbert J. Levickas		22e ADDRESS		5404 East Drive, Baltimore, Md. 21227		
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL		3-4-1969		Loudon Park Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Howard H. Hubbard, 4107 Wilkens Ave. 21229				DATE MAR 5 1969		<u>William J. Jones</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First JESSE		Middle LOCKARD		Last LOCKARD		2a DATE OF DEATH Month Day Year J MARCH 7 1969		2b HOUR 5 AM
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH JULY 24, 1898		6 AGE (In years last birthday) 69 70 YRS		IF UNDER YEAR MONTHS DAYS 1969		IF UNDER 24 HRS HOURS MIN 5
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE		Md		
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NIGHT WATCHMAN		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived or institution. Residence before admission) STATE MARYLAND		13b COUNTY CARROLL		13c CITY OR TOWN WESTMINSTER		13d INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER OLD BALTIMORE ROAD		
14 FATHER'S NAME First Middle Last JAMES LOCKARD		15 MOTHER'S MAIDEN NAME First Middle Last H ELEAN COLEMAN								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES WW II		16b SOCIAL SECURITY NO. 212-18-2025		17 INFORMANT Address CLINICAL RECORDS, VA HOSP. FT. HOWARD, MD.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA										DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										YEARS
(b) OBSTRUCTIVE EMPHYSEMA										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (he) (this hospital) attended the deceased from 1/8/69 , 19__, to 3/7/69 , 19__, that (he) (we) last saw the deceased alive on 3/7/69 , 19__, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death										
22b SIGNATURE John D. Talbert MD		DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 3/7/69
22d PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22e ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND								
23a BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b DATE 3/10/69		23c NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY		23d LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL MD.				
24 FUNERAL DIRECTOR MYERS FUNERAL HOME		ADDRESS WESTMINSTER MD.		25a REC'D BY REGISTRAR MAR 11 1969		25b REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03553

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03547

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ELSIE			First Middle Last F. LONG			2a. DATE OF DEATH 3 Month 17 Day 69 Year			2b. HOUR 1:03 PM		
3. SEX FEMALE			4. RACE White			5. DATE OF BIRTH Feb. 12, 1889			6. AGE (In years last birthday) 77 YRS		
7a. BIRTHPLACE (State or foreign country) Balto. Co.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Reisterstown			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME Lewis E.			First Middle Last			15. MOTHER'S MAIDEN NAME Rachael Monfoot			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes			16b. SOCIAL SECURITY NO. 218-46-2397			17. INFORMANT Mrs. Frank Adams			Address Chatsworth Ave. Reist. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERIPHERAL FAILURE 2001 DUE TO, OR AS A CONSEQUENCE OF (b) OLD CASE OF LYMPHO SARCOMA DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 69 , to 3/17 , 19 69 , that (I) (we) last saw the deceased alive on 3/17 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Neeraja Thakur			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/17/69		
22d. PHYSICIAN'S NAME (Type) NEERAJA THAKUR			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 20, 69			23c. NAME OF CEMETERY OR CREMATORY Grace Methodist			23d. LOCATION (City or Town) (County) (State) Ridge Rd. & Falls Rd. Balto.		
24. FUNERAL DIRECTOR J. F. Eline & Sons			ADDRESS Reisterstown, Md.			25a. REC'D BY REGISTRAR MAR 20 1969			25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (11-64)
30M REV 1-64

03554		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03548	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Theodore				Lucantoni	Month 3 Day 23 Year 1969		M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Male	Cau.	3-2-1887			82 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Md.		
Italy	U.S.A.			Baltimore			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Parkville	8301 Glen Road		Retired		Tailor		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Md.	Baltimore	Parkville		8301 Glen Road 21236			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Unknown					Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		215-01-1087A		Mrs Ida Lucantoni 8301 Glen Road 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease						1/2 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Previous Stroke							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from July 1967, to 3/23, 1969, that (I) (we) last saw the deceased alive on 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leon E. Kassel				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/24/69		
22d. PHYSICIAN'S NAME (Type) LEON E. KASSEL, M.D.				22e. ADDRESS 3501 ST. PAUL ST. Balt, Md 21218			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial	24-26-1969	Parkwood Cemetery		Parkville Balto, Md.			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				MAR 27 1969			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03555		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03549		
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
FREDERICK M. LUCHS					Mar - Month 17 Day		Year 1969 10 P M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS
Male	White	NOV. 16 1890		78 YRS		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10a. CITY OR TOWN OF DEATH		
SWITZERLAND	U.S.A.			BALTO.		Catonsville Md.		
11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Summit Nursing Home		ENG.		RET.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Maryland		Baltimore	Catonsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	907 Rambling Vln			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
Unknown					Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
No				R.E. RUCKSTAHL				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4124 IMMEDIATE CAUSE (a)		ASCUD		?				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)				
DUE TO, OR AS A CONSEQUENCE OF		DUE TO OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. - Month - Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (th's hospital) attended the deceased from JAN 3, 1969 to March 17, 1969, that (I) (we) last saw the deceased alive on 2-24-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
Earl Pass MD		3-17-69		I. EARL PASS				
22e. ADDRESS		4001 Wilkens Ave						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Cremation		3/18/69		LONDON PARK		BALTO. Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
E.S. MALNAB		21228		MAR 19 1969		Malnab, Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-57-10
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Clifton			I.		Lyle				March 10, 1969		9:41 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male			White			7-24-1911			158 3/4 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
West Va.			2122						Baltimore			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph			Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1406 Taylor Ave. 21234		
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME	
Edward J. Lyle												Celia V. Lyle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			Address				
			233 76-3466			Walter W. Wallow			Wallow, Walter W. Wallow				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction.</u>													
4109 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from March 9, 1969, to March 10, 1969, that (I) (we) last saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. REGISTRAR'S SIGNATURE	
Ramon P. Lopez			March 10, 1969			Ramon P. Lopez, M.D.			7620 York Road, Towson, M. 21204			Walter W. Wallow	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCAT ON (City or Town) (County) (State)				
Burial			Mar 11/69			Catholics			Catholics			W. J. J.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE				
Shirley J. Herwig			2024 Calhoun			MAR 13 1969			Walter W. Wallow				



03557

CERTIFICATE OF DEATH

03551

1 DECEASED-NAME (Type or print) LILY HELEN LYON			2a. DATE OF DEATH Month March Day 11 Year 1969			2b. HOUR 1:45A M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH 2 April 1900		6. AGE (in years last birthday) 68 YRS.		7. UNDER 1 YEAR MONTHS 1 DAYS 1 HOURS 1 MIN	
7a. BIRTH-PLACE (State or foreign country) Baltimore Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Cockeysville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garman Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Same			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 206 Garman Road	
14. FATHER'S NAME First William M. date Clyde Last Grove			15. MOTHER'S MAIDEN NAME First Ella Middle M Cord Last Garman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Husband		Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) meningoma - spheroel - Lt 2259 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH- 7 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1957 to March 1969 , that (I) (we) last saw the deceased alive on 28 February 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walter T. Kees		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1 March 1969			
22d. PHYSICIAN'S NAME (Type) WALTER T. KEES		22e. ADDRESS Cockeysville, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/4/69		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY		23d. LOCATION (City or Town) (County) (State) COCKEYSVILLE MD.			
24. FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

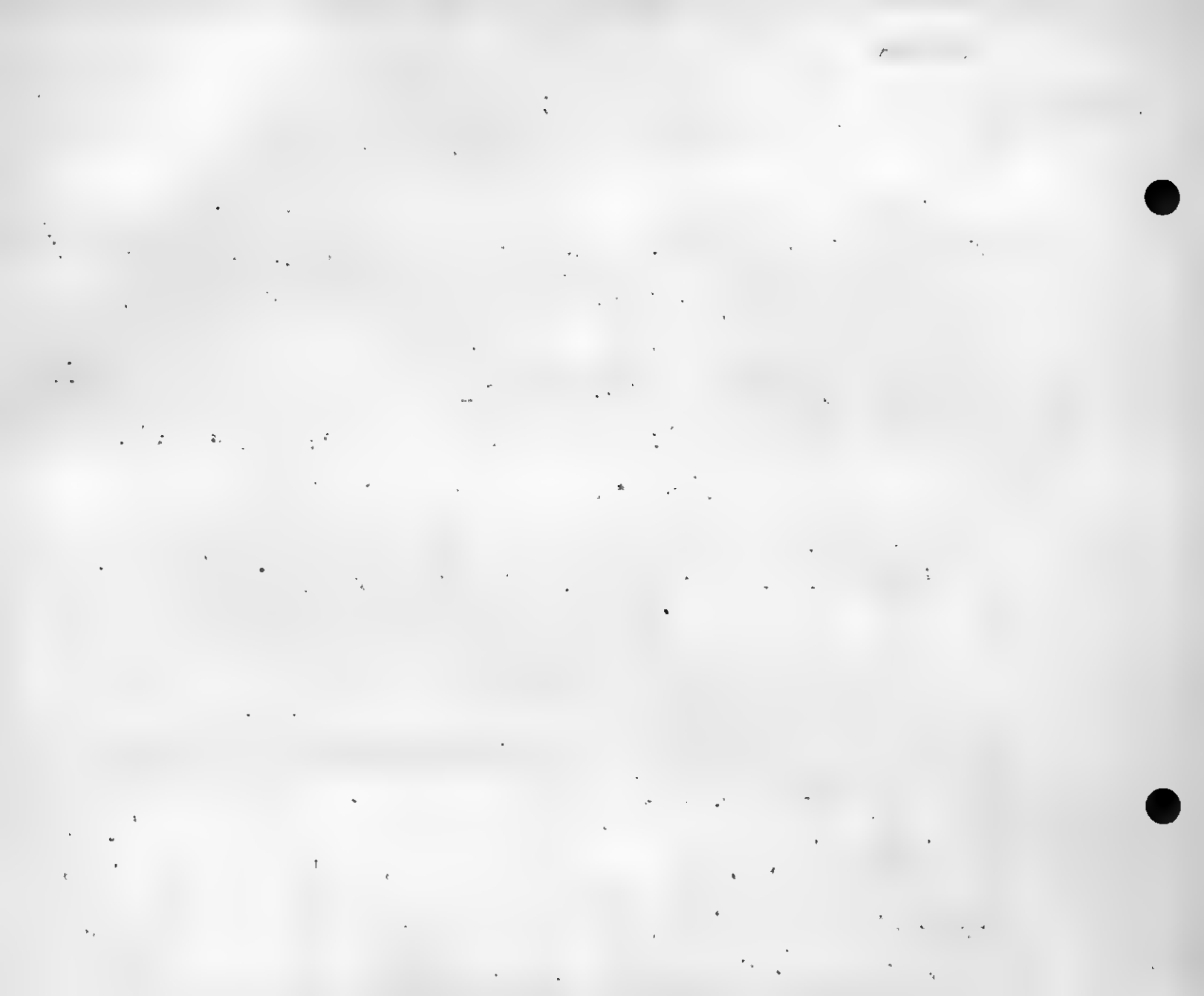
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/2

1. DECEASED NAME (Type or print) <u>George H Mack</u>		2a. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1969</u>		2b. HOUR <u>1:38 PM</u>
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH <u>3/4/1890</u>		6. AGE (In years last birthday) <u>79</u> YRS
7a. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Baltimore</u>	
10. CITY OR TOWN OF DEATH <u>Batonville Md.</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1228 Newfield Rd.</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Technician</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE <u>Md.</u>	13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>1228 Newfield Rd.</u>
14. FATHER'S NAME First <u>John</u> Middle <u>Mack</u> Last <u>Mack</u>	15. MOTHER'S MAIDEN NAME First <u>Sylvia</u> Middle <u>Kelly</u> Last <u>Kelly</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16b. SOCIAL SECURITY NO. <u>214-18-2295A</u>	17. INFORMANT <u>W. M. Mack Jr.</u>		Address <u>1589 Dingleside Lane</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart failure</u> <u>44-9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>Pulmonary Emphysema, Rheumatoid</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. _____ Day _____ Year <u>19</u> P.M. _____	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 27/69</u> to <u>3/28/69</u> , that (I) (we) last saw the deceased alive on <u>3/23/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Christian S. Mass</u>	DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>3/28/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Christian S. Mass</u>	22e. ADDRESS <u>3459 St. John's Lane Ellicott City Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/2/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cmn.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Cavanagh & Son Inc.</u>	ADDRESS <u>901 Hopkins St. 23rd.</u>	25. RECEIVED BY REGISTRAR DATE <u>APR 1 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03559

03553

1 DECEASED NAME (Type or Print)		First WALTER	Middle N.	Last MACK	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3/19 19 69		2b HOUR M
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 10/12/25	6 AGE (In years last birthday) 40 43 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS Min.	2c DATE PRONOUNCED DEAD Month March Day 19 Year 19 69	2d HOUR 9:55 P.M.
7a BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Medical Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK		12b KIND OF BUSINESS OR INDUSTRY STORE	
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Md.		13b COUNTY Baltimore	13c CITY OR TOWN Towson	3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 726 Bosley Avenue		
14 FATHER'S NAME First Middle Last WALTER S. MACK			15 MOTHER'S MAIDEN NAME First Middle Last SARAH L. MYERS				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO (If yes give war or dates of service) 212-20-4774		17 INFORMANT ADDRESS WALTER MACK- 726 BOSLEY AVE.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-cranial injuries 8161 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOURS MIN. 9:15 P.M. 3/19 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger in auto that overturned several times			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f LOCATION Street or R.F.D. No. City or Town County State Rte #695 west of Belair Rd. cut-off Baltimore Md.			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED March 20, 1969	
23a BURIAL, CREMATION, RECOVERY (Specify)		23b DATE 3/24/69		23c NAME OF CEMETERY OR CREMATORY Pleasant Rest		23d LOCATION (City or Town) (County) (State) Towson, Balto. Co. Md.	
24 FUNERAL DIRECTOR Wm. J. Chatman, Jr - 1701 Mt. Cullough St. Balto. Md.				25a REC'D BY REGISTRAR DATE MAR 24 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

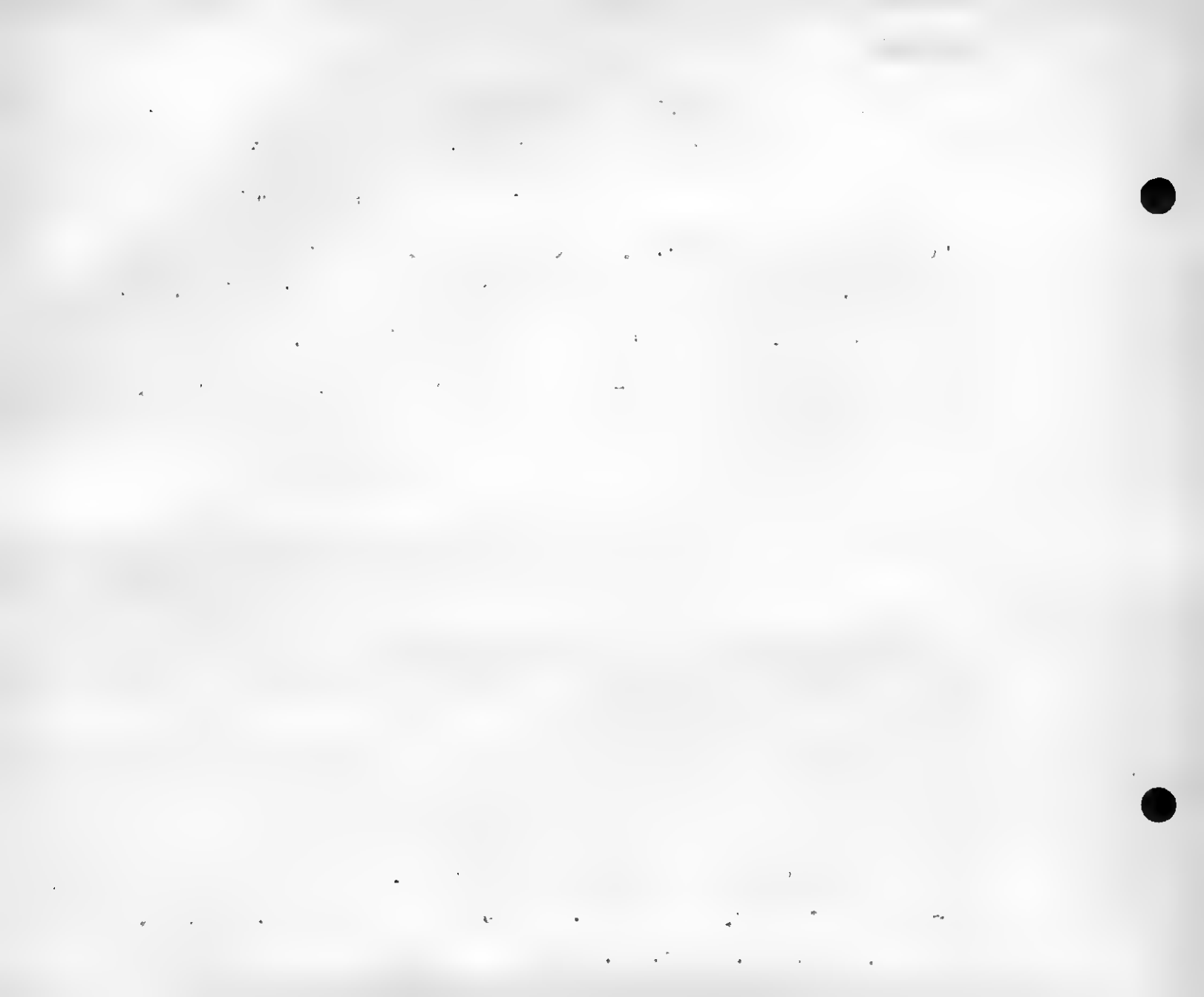
1

03560

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03554

1. DECEASED NAME (Type or print) First Middle Last ARTHUR HENRY MANLY			2a. DATE OF DEATH Month Day Year 3 16 69			2b. HOUR 3:30^a			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 12/28/03		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GREATER BALTO. MED. CENT.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 804 E. 35th. Street			
14. FATHER'S NAME First Middle Last John William Manly			15. MOTHER'S MAIDEN NAME First Middle Last Frieda E. Becker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-09-8079		17. INFORMANT Address Mrs. Dawn Shipman, Glen Rock, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF LUNG 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 69 , to 3/16 , 19 69 , that (I) (we) last saw the deceased alive on 3/15 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (diagnose) view the body after death.									
22b. SIGNATURE Neeraja Thakur		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-16-69			
22d. PHYSICIAN'S NAME (Type) NEERAJA THAKUR		22e. ADDRESS 6701 N. CHARLES ST.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/19/69.		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE <i>John Charles George</i>			



03561

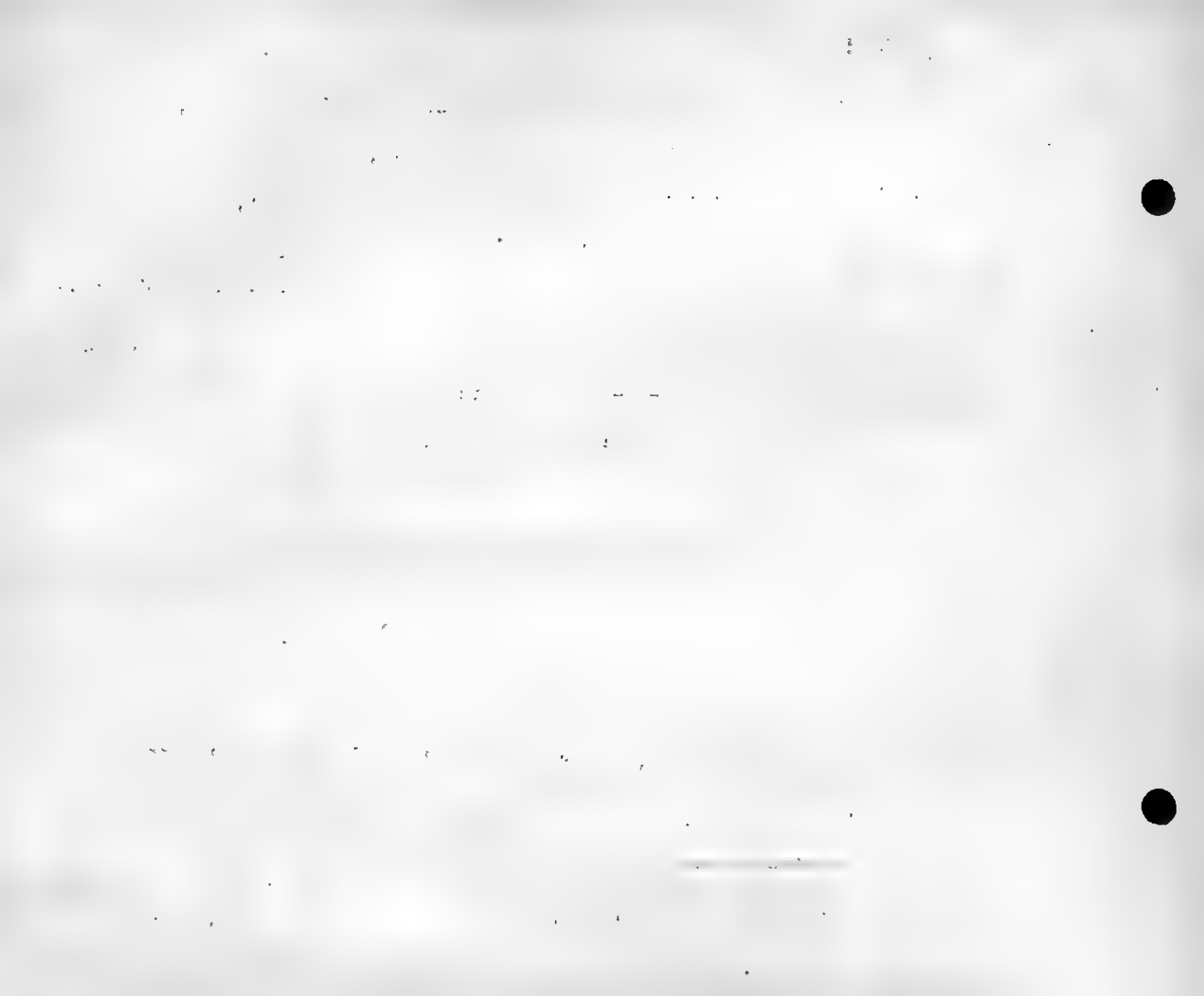
CERTIFICATE OF DEATH

03555

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
ANNA				CATHERINE	MARTELLE	MARCH			Month	Day
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)	
FEMALE			WHITE			DECEMBER 18, 1914			54 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
MARYLAND			U.S.A.						BALTIMORE, Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done in most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			ST. JOSEPH HOSPITAL			HOMEMAKER				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
STATE MARYLAND						BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
3212 E. NORTHERN PKWY. #14			First Middle Last			First Middle Last			Yes, no, or unknown (If yes give war or dates of service)	
			John D Lasseth			Mary Caprel			No	
16b. SOCIAL SECURITY NO.			17. INFORMANT			17. INFORMANT			Address	
215-07-1121			Mr Michael L Martelle			Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis.										
1950 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from March 15, 1969, to March 31, 1969, that (I) (we) last saw the deceased alive on March 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
Benjamin DelCarmen, M.D.										
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										
22c. DATE SIGNED March 31, 1969										
22d. PHYSICIAN'S NAME (Type) Benjamin DelCarmen, M.D.										
22e. ADDRESS 7620 York Road, Towson, Md. 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			4/3/69			Holy Redeemer			Baltimore, Maryland	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Leonard J Ruck Inc. Baltimore, Maryland			DATE APR 1 1969			Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03562

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03556

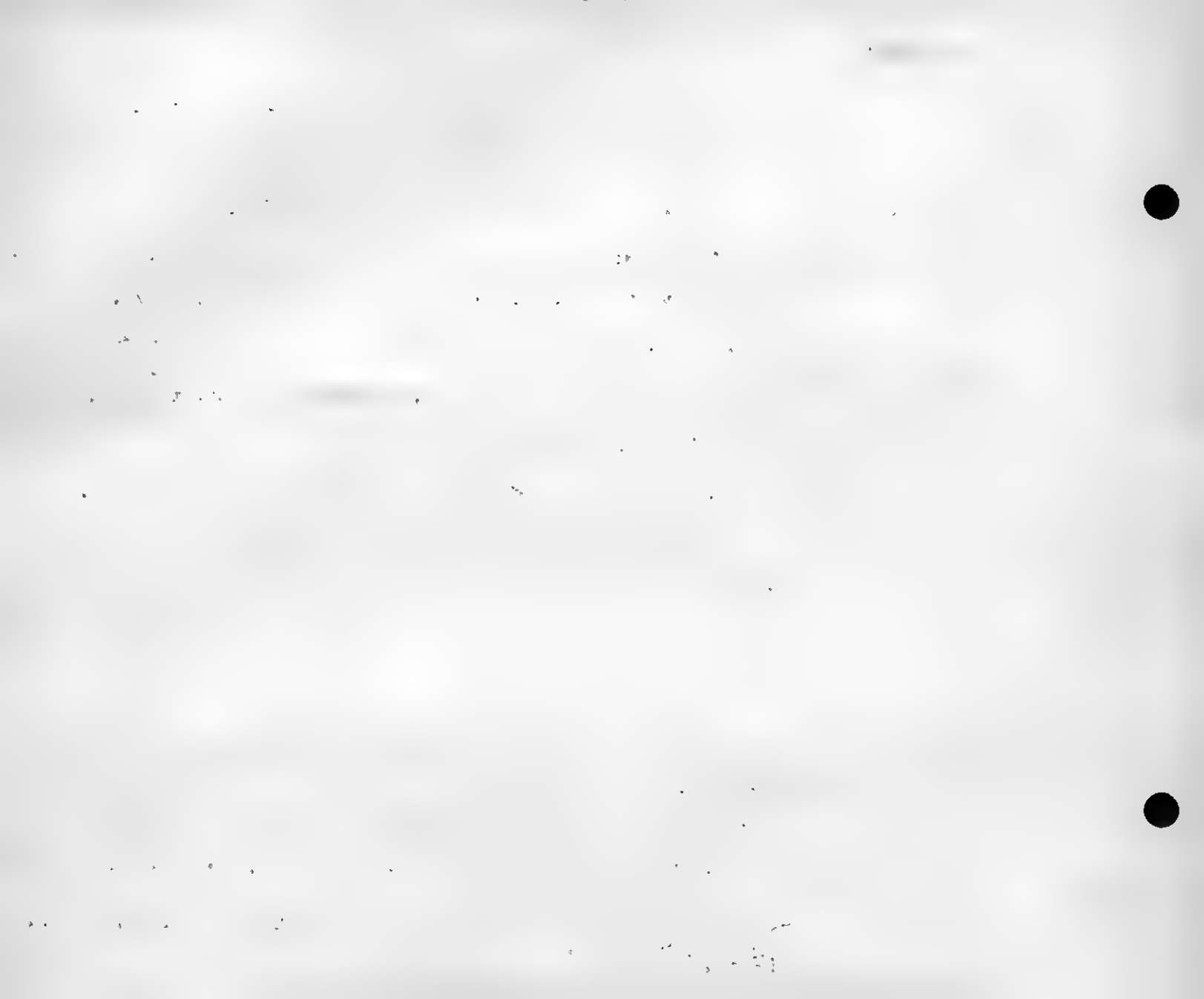
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Mar 17, 1969				2b HOUR 11:19 AM		
JOSEPHINE		MARTELO												
3 SEX F	4 RACE W	5. DATE OF BIRTH MAR 19 1944		6 AGE (In years last birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month MAR Day 17 Year 1969				2d HOUR 2 PM
7a BIRTHPLACE (State or foreign country) NY		7b. CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.								
10 CITY OR TOWN OF DEATH ESSEX				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11 WARREN RD.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE NY				13b COUNTY QUEENS		13c CITY OR TOWN LONG ISLAND		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3519 12th St				
14 FATHER'S NAME FRANK CAMPISE				15. MOTHER'S MAIDEN NAME ANNA CORSO										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK				16b SOCIAL SECURITY NO (If yes give war or dates of service) 065 01-5575		17 INFORMANT MARIE MEEHAN				ADDRESS 11 WARREN RD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>H-S-C-V- DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>														
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>None</u>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>MELVIN B. DAVIS, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED MAR 18, 1969						
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE 3/18/69		23c NAME OF CEMETERY OR CREMATORY ST. RAYMONDS				23d LOCATION (City or Town) (County) (State) BRONX NEW YORK				
24 FUNERAL DIRECTOR CHINESE CHEUNG SANG				ADDRESS N.Y. 22 MULBERRY				25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
304 REV 1-58

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03563					03557				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First	Middle	Last	Month	Day	Year				
JOHN	VALENTINE	MARTIN	March	12,	1969			4:05A	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		July 14, 1885		83 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH			
Balto., Md.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Middle River		418 Katherine Ave.		Retired		Store-Keeper			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Baltimore		Middle River <input type="checkbox"/> NO <input checked="" type="checkbox"/>		418 Katherine Ave.			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First	Middle	Last	First	Middle	Last				
John	V.	Martin	Anna	Griff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		217-01-1316		Barbara A. Grendo: 418 Katherine Ave.		Balto., 21221, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>								1 day	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertensive heart disease</u>								7 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>last.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 6, 1962</u> , to <u>Feb 12, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Joseph Miceli</u>								3/14/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
JOSEPH MICELI				108 S. Taylor Ave., Baltimore, 21221, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
Burial		3-15-69.		Sacred Heart Cemetery		7401 German Hill Rd., Ba. Co.,			
24. FUNERAL DIRECTOR				25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Charles S. Zeiler</u> 6224 Eastern Ave. Balto., 21224, Md.				DATE		MAR 17 1969			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03564

03558

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First Clifford		Middle G.		Last Marvel		2a DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year		2b HOUR 11:00 P.M.	
3 SEX Male	4 RACE White	5 DATE OF BIRTH Apr. 26, 1890	6 AGE (in years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Mar Day 11, Year 1969		2d HOUR 12:45 P.M.	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
1d. CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 2638 Yorkway				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Automobil		
13a USUAL RES DENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c. CITY OR TOWN Dundalk		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2638 Yorkway			
14. FATHER'S NAME First Middle Last Martin Marvel		15. MOTHER'S MAIDEN NAME First Middle Last Anne Dukes		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS Mrs. Echel Marvel, 2638 Yorkway 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>H-S-C-V-Disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.B. Davis, M.D. 6800 MORNINGTON ROAD M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/13/69	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE Mar. 13, 1969		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City or Town) Colgate, Md.		(County)		(State)	
24 FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.						25a RECEIVED BY REGISTRAR DATE MAR 17 1969		25b REGISTRAR'S SIGNATURE Blanche Jones			

03565

CERTIFICATE OF DEATH

03559

1. DECEASED NAME (Type or print) SAMUEL C. MATTOX			2a. DATE OF DEATH March 14 Day 1969			2b. HOUR 11:22 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2-23-1893		6. AGE (In years last birthday) 76 YRS	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a. USIA. OCCUPATION (Kind of work done during most of working life, even if retired) Operating Engineer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. U.S.A. RESIDENCE (Where deceased administered) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Abner C. Mattox		15. MOTHER'S MAIDEN NAME Lucy A. Shephard		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			
16b. SOC. SEC. NO. 223-07-9700		17. INFORMANT Robert C. Quail 7237 Sindall Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 14, 1969, to March 14, 1969, that (I) (we) last saw the deceased alive on March 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jaime Punzalan				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-14-69	
22d. PHYSICIAN'S NAME (Type) Jaime Punzalan, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-17-69		23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial		23d. LOCATION (City or Town) (County) (State) Richmond, Va.	
24. FUNERAL DIRECTOR Johnson F.H., 8521 Loch Raven Blvd., Baltimore, Md.				25a. REC'D BY REGISTRAR DATE MAR 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 10-1 (4)
304A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
03566						CERTIFICATE OF DEATH			03560			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR			
Earl T. Maxwell						3 Month 3 Day 28 Year 69			1 P. M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		W		OCT. 4, 1903			65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
OHIO		U. S. A.				BALTO. Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Randalls Town			Chapel Hill Conv. Home			PRINTER						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md			BALTO		CATONSVILLE				6 N. Rolling Rd.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
FRANK MAXWELL			EDNA THOMPSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
NO			277-01-2025		MARY M. KEENEY 6 N. Rolling Rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis - ASCVD - Chronic Brain S.</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>10-19-1965</u> to <u>3-28-1969</u> , that (I) (we) last saw the deceased alive on <u>3-28-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED						
CESAR VALLE CAVERO						3-28-69						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
CESAR VALLE CAVERO		8629 Liberty Rd										
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
BURIAL		3/31/69		Meadow Ridge Cem		Howard Co MD						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
E. S. MacNabb		301 Frederick Rd BALTO 25, MD		APR 1 1969		J. Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

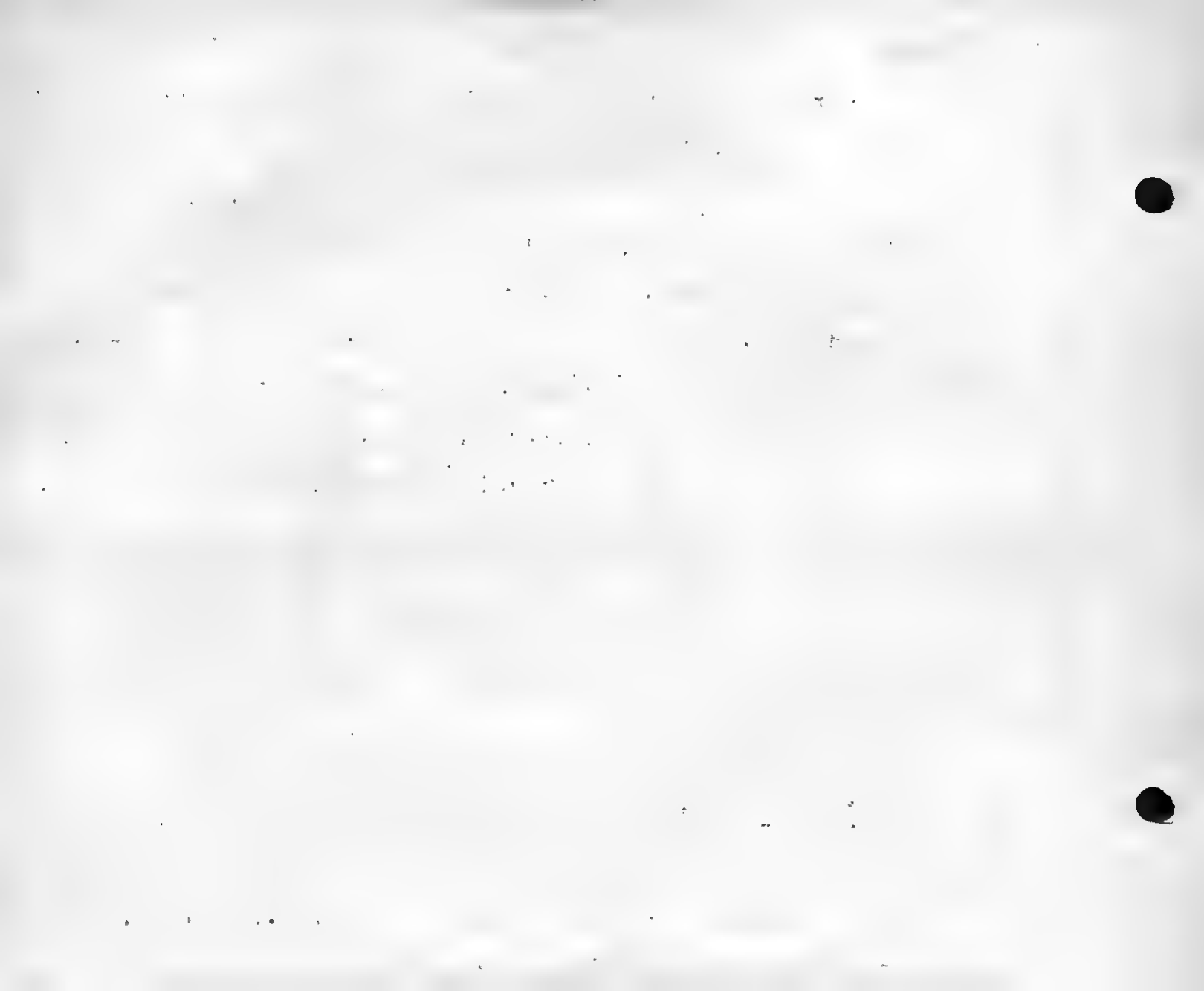
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03567

CERTIFICATE OF DEATH

03561

1 DECEASED NAME (Type or print) Kathryn		First	Middle	W	Lost	2a DATE OF DEATH Month March Day 12 , Year 1969		2b. HOUR 11:18 M	
3 SEX female		4 RACE white		5. DATE OF BIRTH July 7, 1916		6 AGE (In years lost birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d INS DE C'TY. LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 5 Winthrop Court	
14. FATHER'S NAME Maurice H. Hoppert		First	Middle	Lost	15 MOTHER'S MAIDEN NAME Pessie Grimm		First	Middle	Lost
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO 216-05-5496		17 INFORMANT Mr. Bernard J. McGarity		Address Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA - PHARYNGITIS DUE TO, OR AS A CONSEQUENCE OF (b) URI - VIRUS-PHARYNGO-TRACHEITIS DUE TO, OR AS A CONSEQUENCE OF (c) UNK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-21-1969 to 3-12-1969 , that (I) (we) lost the deceased on 3-11-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Anthony F. Carozza					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-13-69.		
22d. PHYSICIAN'S NAME (Type) Dr. Anthony F. Carozza					22e. ADDRESS 5217 York Road				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/1969		23c NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		23d LOCATION (City or Town) (County) (State) Texas, Balto. Md			
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd Balto.					25a REC'D BY REGISTRAR MAR 17 1969		25b REGISTRAR'S SIGNATURE Charles Moore		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03568 CERTIFICATE OF DEATH 03562									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MURRIL			JOSEPH			McHUGH			March 3 1969 8:45 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 24 HRS
MALE		WHITE		JUNE 18, 1921			47 YRS.		MONTHS DAYS HOURS M N
7a. BIRTH-PLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
MARYLAND			U.S.A.			BALTIMORE			Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
FORT HOWARD			Veterans Administration Hospital			IRON WORKER			
13a. USUAL RESIDENCE (Where deceased lived if not in institution)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
STATE MARYLAND			BALTIMORE			YES <input type="checkbox"/> NO <input type="checkbox"/>			603 HILLTOP AVENUE
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JAMES J. McHUGH			MARGARET A. KRAMER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			
YES WW-11			214 18 9517			Clinical Rcds, VA Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Congestive heart failure.</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular heart d.</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION					
				Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 2</u> , 19 <u>69</u> , to <u>March 3</u> 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 3</u> 19 <u>69</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <u>(not)</u> view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
<i>Edward J. Bunyor M.D.</i>				3/3/69					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
ERHARD J. BUNYOR, M.D.				VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		3-6-1969		Woodlawn Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR				ADDRESS				25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME				107 Wilkins Av. Balto, Md.				<i>John A. Quaker</i>	
				DATE				MAR 5 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

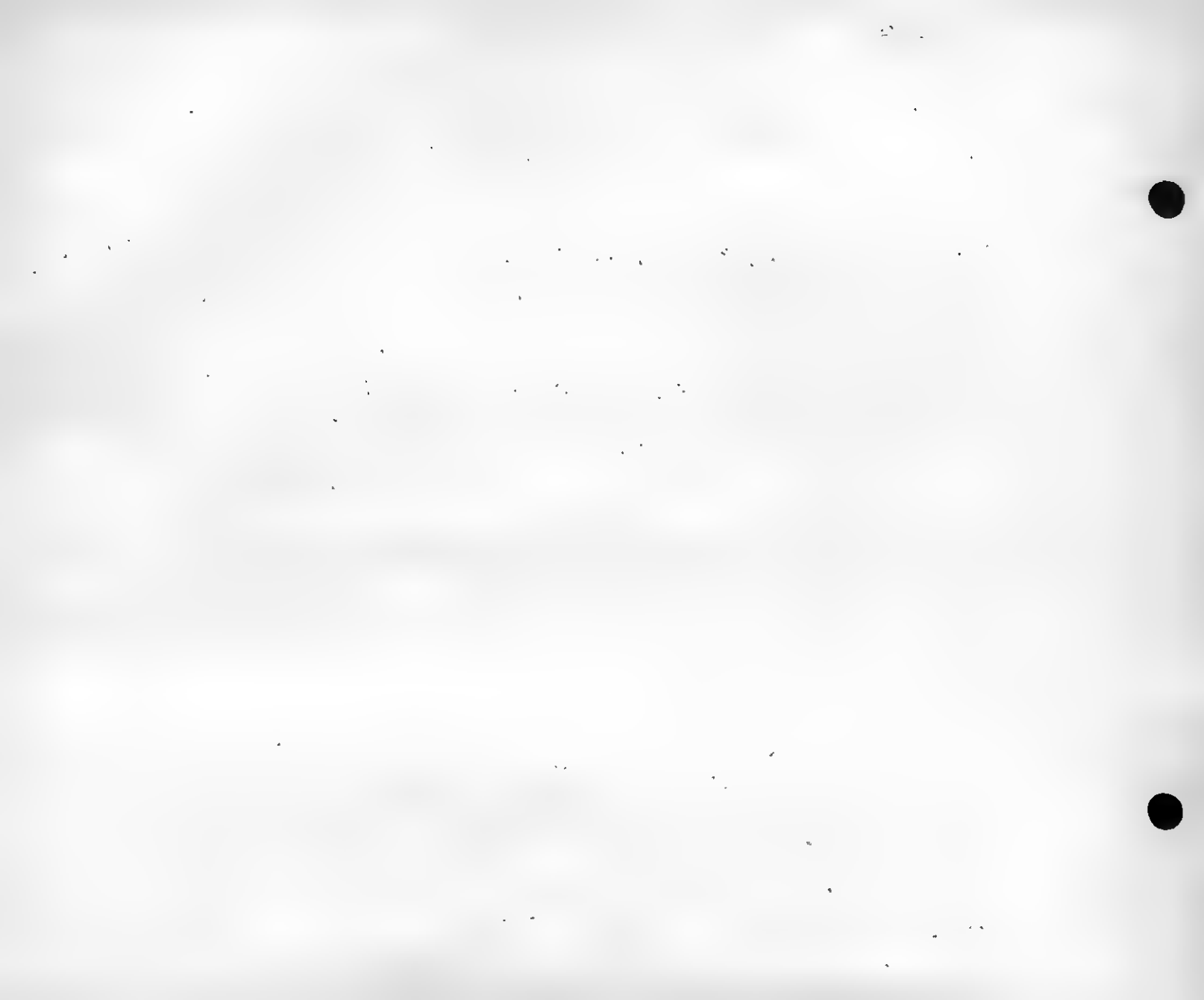
03569

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03563

1. DECEASED NAME (Type or print) William V. McQuaid			2a. DATE OF DEATH Month March Day 26 Year 1969			2b. HOUR 5:55 P.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH Dec. 7, 1902		6 AGE (in years lost birthday) 66 YRS	
7a. BIRTHPLACE (State or foreign country) Ind		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Co.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mid. Forest Haven Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed		12b KIND OF BUSINESS OR INDUSTRY Self-employed	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Ind		13b COUNTY 13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 915 Bayard St. (21223)		14. FATHER'S NAME First unknown Middle unknown Last unknown		15 MOTHER'S MAIDEN NAME First unknown Middle unknown Last unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 813-03-8928		17 INFORMANT Beatrice M. McQuaid		Address 1170 Nantuxen St. (21230)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROSIS CHAGRI VASCULAR DUE TO, OR AS A CONSEQUENCE OF (b) DISEASE - PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) DEGENERATIVE CHANGES							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/26, 1966 , to 3/26, 1969 , that (I) (we) last saw the deceased alive on 3/26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph H. Shaw M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/28/69	
22d. PHYSICIAN'S NAME (Type) Joseph H. Shaw M.D.				22e. ADDRESS 5800 Edmonstone Ave. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/29/1969		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Ind.	
24. FUNERAL DIRECTOR Fun. & Burial, Inc. 901 Holladay St. Balt. Ind.				25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE William F. Sanders	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First <i>Margaret</i>	Middle <i>Meier</i>	Last	2a. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1969</i>		2b. HOUR <i>6A.</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 30, 1888</i>		6. AGE (In years last birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co.</i> Md			
10. CITY OR TOWN OF DEATH <i>Balto. (Overlea)</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4303 Belmar Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>4303 Belmar Ave.</i>	
14. FATHER'S NAME <i>John Lehner</i>			First <i>John</i>	Middle <i>Lehner</i>	Last	15. MOTHER'S MAIDEN NAME <i>Mary</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>216-32-3125</i>		17. INFORMANT <i>Frederick H. Meier - 4303 Belmar Ave.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>27 August, 1967</i> , to <i>March 4, 1969</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>March 3, 1969</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death.									
22b. SIGNATURE <i>A.C. Alevizatos</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>4 March 69</i>	
22d. PHYSICIAN'S NAME (Type) <i>A.C. ALEVIZATOS, M.D.</i>		22e. ADDRESS <i>1309 5th Ave. N.E.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-7-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>			
24. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>MAR 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03571		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03565	
1. DECEASED-NAME (Type or print) First Middle Last <i>Samuel — Melnick</i>			2a. DATE OF DEATH Month Day Year <i>Jan 20 69</i>			2b. HOUR <i>3:24 M</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>[REDACTED]</i>		6. AGE (In years last birthday) <i>81</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County</i> Md.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Balt. Co. Gen. Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>MERCHANT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RETAIL</i>	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Baltimore</i>		13b. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY - IN 1ST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>6316 Greenspring Ave</i>	
14. FATHER'S NAME First Middle Last <i>Philip — Melnick</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>[REDACTED] ROSE ?</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>[REDACTED]</i>		17. INFORMANT Address <i>MRS. ROSE MELNICK, 6316 GREENSPRING AVE., APT. 206</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular Accident, thrombosis, multiple</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive arteriosclerotic heart Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>[REDACTED]</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-11-1969</i> , to <i>3-20-1969</i> , that (I) (we) last saw the deceased alive on <i>3-20-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <i>G. Marfoni, MD</i>				22c. DATE SIGNED <i>3-20-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>G. MARFONI</i>				22e. ADDRESS <i>BALTIMORE COUNTY GENERAL HOSPITAL</i>			
23a. B. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-21-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ADAS ISRAEL</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON, D. C.</i>	
24. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>				25a. REC'D BY REG. STRAR <i>DATE MAR 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03572

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03566

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE OF DEATH EST. <input type="checkbox"/> MATED <input checked="" type="checkbox"/>		Month Day Year		2b HOUR			
ADA						MELTON				19		M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			
female		negro		3-18-1918		50 YRS						March 10, 1969			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						2d HOUR			
Virginia		USA				Baltimore						12:00 P. M.			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Towson				Greater Balto. Med. Center											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland				Baltimore				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1000 E. 20th Street	
4 FATHER'S NAME				5 MOTHER'S MAIDEN NAME											
Robert Brown				Unknown											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS			
				216-24-3501				Gail Bridges				2410 Asquith St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease															
4124 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				19 P. M.											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town			
												County			
												State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type)				Werner U. Spitz, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				3/11/69			
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
								ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				3-14-69				Arbutus Mem. Ch.				Baltimore Md.			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Burlington S. Phillips				1725 N. Meade St.				MAR 18 1969				[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03573

CERTIFICATE OF DEATH

03567

1 DECEASED NAME (Type or print) HELEN S. MEYERS			2a. DATE OF DEATH Month 3 Day 5 Year 69			2b. HOUR 3:55 M			
3 SEX Female		4. RACE Negro		5. DATE OF BIRTH 9-26-1895		6. AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Corbit, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.			
10. CITY OR TOWN OF DEATH Baltimore, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GBMC		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Hereford		13c. CITY OR TOWN Big Falls Road		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME First Middle Last GEORGE STERRETT			15 MOTHER'S MAIDEN NAME First Middle Last MARY STERRETT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No.		16b. SOCIAL SECURITY NO		17 INFORMANT Mr. Albert B. Myers		Address Big Falls Road			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung with widespread metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchopneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/9/ , 19 69 , to 3/5/ , 19 69 , that (I) (we) lost saw the deceased alive on 3/5/ , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Rudiger Breiteneker</i>		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/69			
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.		22e. ADDRESS Greater Baltimore Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-8-69		23c. NAME OF CEMETERY OR CREMATORY St. Luke Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Hereford, Md.			
24. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.		25a. REC'D BY REGISTRAR DATE MAR 7 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03574

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03568

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3/30 1969			2b. HOUR 10:30 P.M.
PAULINE			EVELYN			MILES			
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR 12:45 A.M.
female	white	Oct. 18, 1921	48 4/5					March 31 1969	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8523 Glen Michael - 104		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Social Security		12b KIND OF BUSINESS OR INDUSTRY U.S. Government			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 8523 Glen Michael - 104
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Michael C. Smith						Imogene C. ?			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO. (If yes give war or dates of service) 215-12-3124		17 INFORMANT Mrs. Donna Ruckart			ADDRESS 5604 Gwynn Oak Ave. #	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate Overdose</u> 9500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. UNK P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subj. ingested an overdose of pills					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State Baltimore, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 3/31/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 13, 1969		Loudon Park		Baltimore Md.			
24. FUNERAL DIRECTOR John T. Stansbury, Sr.				ADDRESS 6411 Windsor Mill Rd. 7		25a. REC'D BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03575										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03569																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
JOHN - - - MILLER										March 6 1969										M																																							
3 SEX Male										4 RACE White										5 DATE OF BIRTH July 23, 1892										6 AGE (In years last birthday) 76 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Maryland										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Baltimore										Mo																			
10 CITY OR TOWN OF DEATH Fort Howard										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Adm. Hospital										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor										12b KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard																													
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b COUNTY Anne Arundel										13c CITY OR TOWN Pasadena										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e STREET AND NUMBER RFD #9 RT 162																			
14 FATHER'S NAME First Middle Last LEWIS - - - MILLER										15 MOTHER'S M.A.DEN NAME First Middle Last MARGARET - - SCHLINE																																																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes give war or dates of service) WW-1										16b SOCIAL SECURITY NO 214 12 95 72										17 INFORMANT Clinical Rcds VA Hospital, Ft Howard Md.										Address																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
4109										(b) ARTERIOSCLEROTIC HEART DISEASE										DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 5, 19 69, to Mar. 6, 19 69, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 6, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																																																											
22b SIGNATURE Madhav S. Barharpurkar										22c DATE SIGNED 3/6/69										22d PHYSICIAN'S NAME (Type) MADHAV BARHARPURKAR, M.D.										22e ADDRESS VA Hospital, Fort Howard, Md.																													
23a BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) BURIAL										23b DATE 3/10/69										23c NAME OF CEMETERY OR CREMATORY Baltimore National										23d LOCATION (City or Town) (County) (State) Baltimore, Md.																													
24 FUNERAL DIRECTOR Thomas E. Fisher Funeral Home										25a REC'D BY REG STRAR 1950 Eastern Ave Balto. Md.										25b REGISTRAR'S SIGNATURE																																							

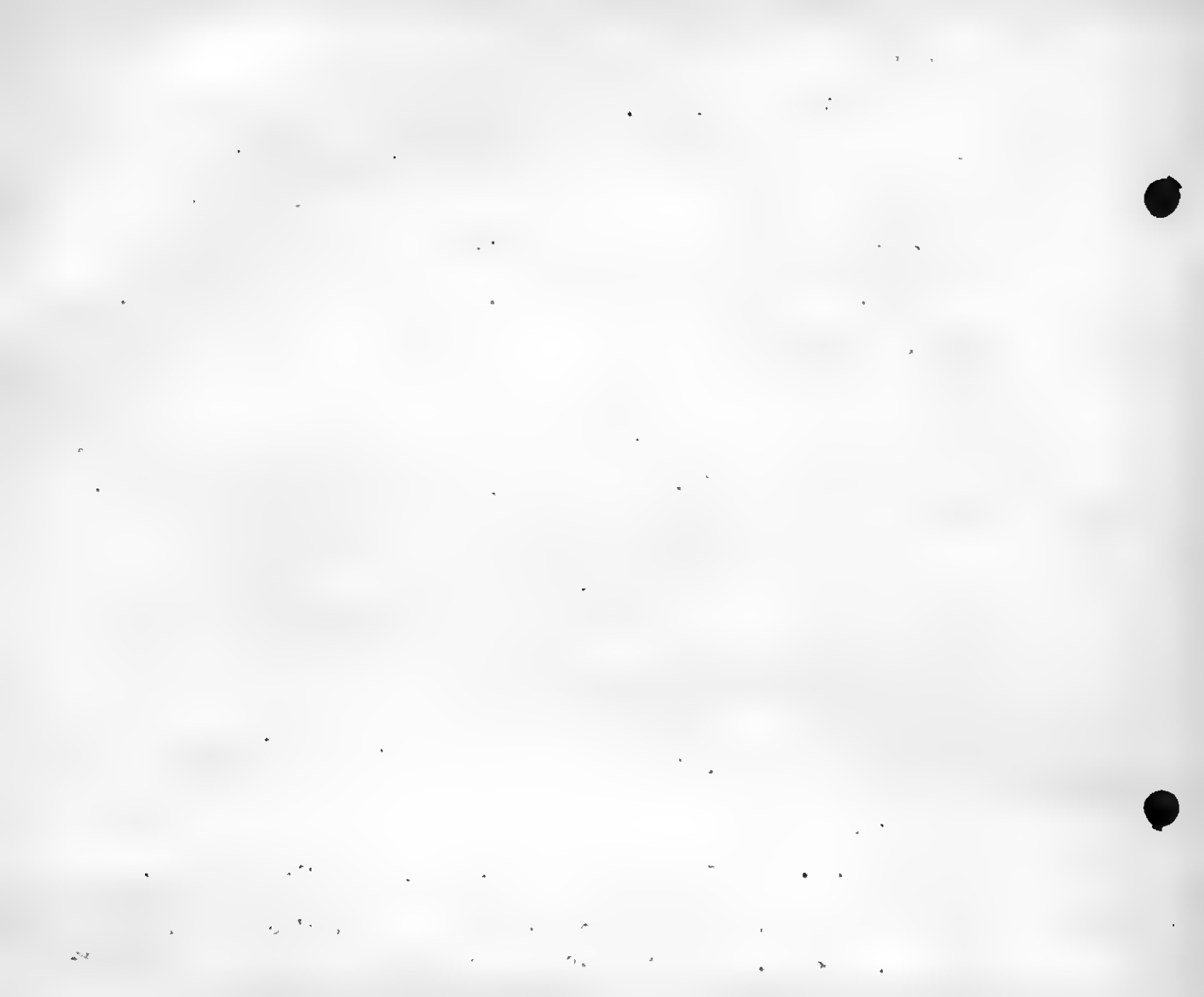
03576

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Moeller, Pauline C.					3/21/69		11 AM	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
female		caucasian		1/24/95		74 YRS.		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		Stella Maris Hospice		Sewing				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Baltimore		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1424 Holbrook St.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
John F. Moeller		Edelbrudis Mueller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
No				Hospice records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic venous disease lower extremities</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>year</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Brain Syndrome</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/4/1908</u> , to <u>3/21/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/21/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>David Nage</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/21/69		
22d. PHYSICIAN'S NAME (Type) Dr. J. David Nage				22e. ADDRESS Mockingbird Lane, Towson, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3/25/69		Most Holy Redeemer		Baltimore Maryland		
24 FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck Inc. 5305 Harford Road 21214				MAR 24 1969		<u>John H. Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03577

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0357A

1 DECEASED NAME (Type or print) Phyllis		First B. Middle Monaghan Last		2a. DATE OF DEATH Month 3 Day 27 Year 69		2b. HOUR 4:15 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1/10/35		6. AGE (In years last birthday) 34 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) 3409 Orbitan Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 3409 Orbitan Rd		14. FATHER'S NAME First Donald Middle Galgano Last Bock		15. MOTHER'S MAIDEN NAME First Alice Middle Bock Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-30-3060		17. INFORMANT Mr Michael T Monaghan		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural effusion DUE TO, OR AS A CONSEQUENCE OF Pulmonary metastase Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cocaine of the heart DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 d. 2 hrs. 1 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/7/68 , 19 68 , to Present , 19 69 , that (I) (we) last saw the deceased alive on 3/24 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE George J. Richards, Jr. M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/69	
22d. PHYSICIAN'S NAME (Type) George J. Richards, Jr. M.D.				22e. ADDRESS 6701 N. Charles Street #21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/31/69		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Leonard J Ruck Inc, Baltimore, Maryland				25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

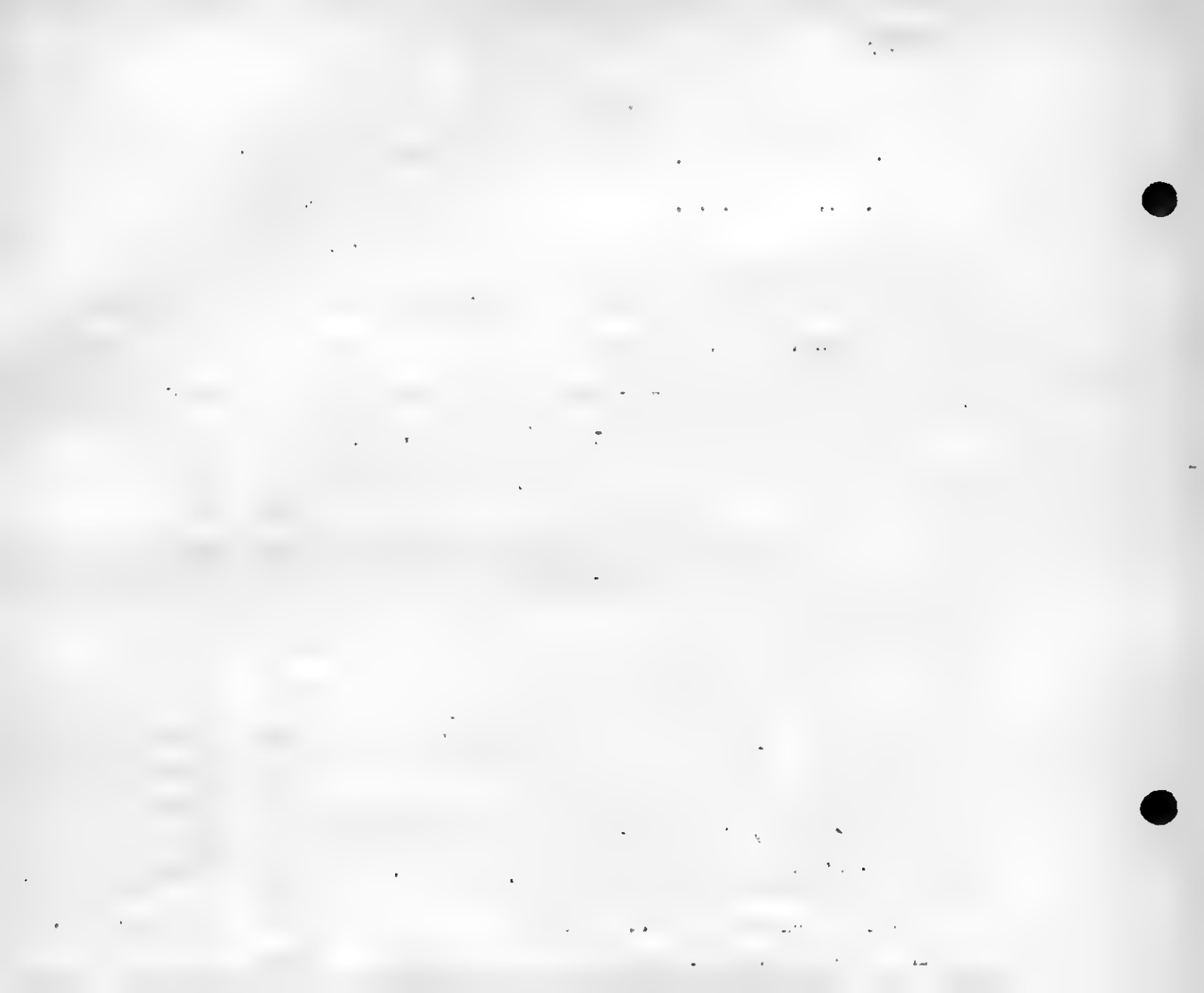
03578

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03572

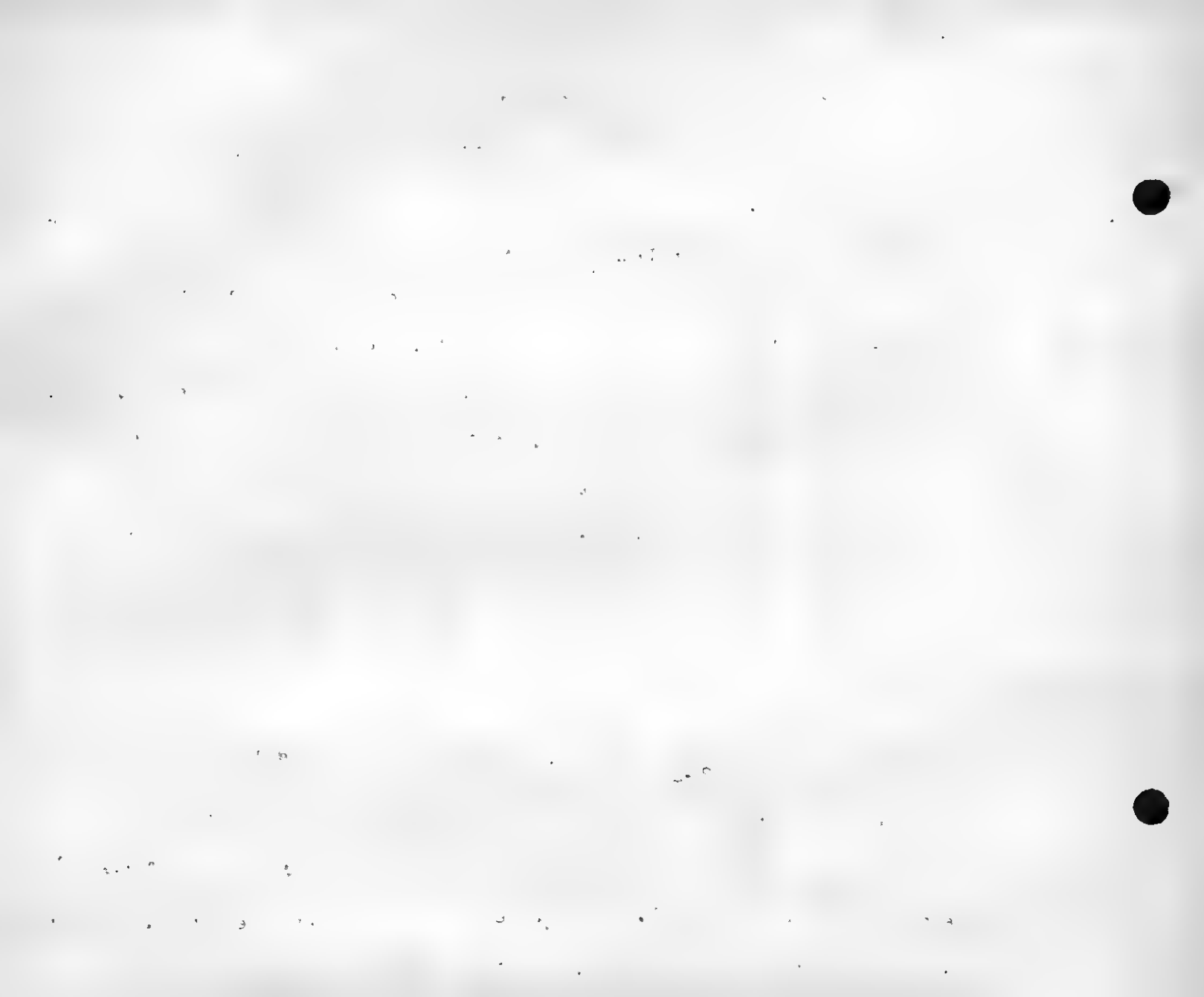
1. DECEASED-NAME (Type or print)		First Della	Middle M.	Last Moore	2a. DATE OF DEATH Month 3 Day 21 Year 1969		2b. HOUR M
3 SEX Female	4 RACE Cau.		5 DATE OF BIRTH 10-30-1902		6 AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Balto. Co.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH White Marsh		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1014 Red Lion Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN White Marsh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 1014 Red Lion Road		14. FATHER'S NAME First Middle Last Edward H. Moore		15. MOTHER'S MAIDEN NAME First Middle Last Della Pugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-48-4734		17. INFORMANT Address 21142 Thomas Haines 1014 Red Lion Road White Marsh			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>402X</u> DUE TO, OR AS A CONSEQUENCE OF <u>Extreme Obesity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1967</u> , to <u>Feb 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 22, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Irving R. Beck</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) IRVING R. BECK M.D.		22e. ADDRESS 901 FUSILLAGE AV Baltimore Md 21220					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-24-1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION (City or Town) (County) (State) Gamble Carroll Co Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03579		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03573	
Film 23a Film 3/7/69 kk		CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or print)		First		Middle		Last	
ROBERT P		MORGAN, JR.					
2a DATE OF DEATH		3 Month		3 Day		69 Year	
2b HOUR		1:55					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
MALE		CAU		11-3-13		55 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				BALTIMORE	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		GREAT BALT MED CENT.		Salesman			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore				13e STREET AND NUMBER	
						42 Acorn Circle, Towson, Md	
14 FATHER'S NAME		First		Middle		Last	
Robert P. Morgan							
15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Margaret F. Forrester							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
Yes		WW 2		212-05-8297		Amy W. Morgan 42 Acorn Circle, Towson, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1041		DUE TO, OR AS A CONSEQUENCE OF		CARDIO RESPIRATORY FAILURE		IMMEDIATE	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b)		METASTATIC CA OF LUNG			
		DUE TO, OR AS A CONSEQUENCE OF		(c)		CARCINOMA OF RECTUM	
						1963	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year					
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work				Street or R.F.D. No.		County	
						State	
22a. I certify that (I) (this hospital) attended the deceased from		2-28		19-69, to		3-3	
saw the deceased alive on		3-2		19-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
B.R. Cho		3-3-69		M.D.		6701 N CHARLES ST BALT, MD	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. LOCATION		City or Town	
						County	
22f. LOCATION		City or Town		County		State	
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)	
Burial		Mar. 6, 1969		Dulaney Valley		Cockeysville, (County) (State)	
23d. LOCATION (City or Town)		County		State			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson 1050 York Rd. 21204				MAR 5 1969		M. J. ...	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

03580

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03574

1. DECEASED NAME (Type or print) Mary Berger Morganstein			2a. DATE OF DEATH 3 Month 14 Day 69 Year			2b. HOUR 3 P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9/17/92		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.				
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co. Gen.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6965 Blanche Rd.	
14. FATHER'S NAME David Berger			15. MOTHER'S MAIDEN NAME Lena Beigleman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO 218-52-2584		17. INFORMANT Hospital Record Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA PANCREAS WITH HEPATIC METASTASES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from FEB. 28, 1969 , to MAR. 14, 1969 , that (I) (we) last saw the deceased alive on MARCH 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Fausto G. Aquino, Jr.						22c. DATE SIGNED 3/14/69		22d. PHYSICIAN'S NAME (Type) FAUSTO G. AQUINO JR. BALTO. COUNTY GEN. HOSP.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried			23b. DATE 3/16/1969		23c. NAME OF CEMETERY OR CREMATORY Moss Mount			23d. LOCATION (City or Town) (County) (State) Balto Maryland		
24. FUNERAL DIRECTOR L. Lewis & Son Inc., 9610 Reisterstown Rd.						25a. REC'D BY REG. STRAR MAR 19 1969		25b. REGISTRAR'S SIGNATURE William J. Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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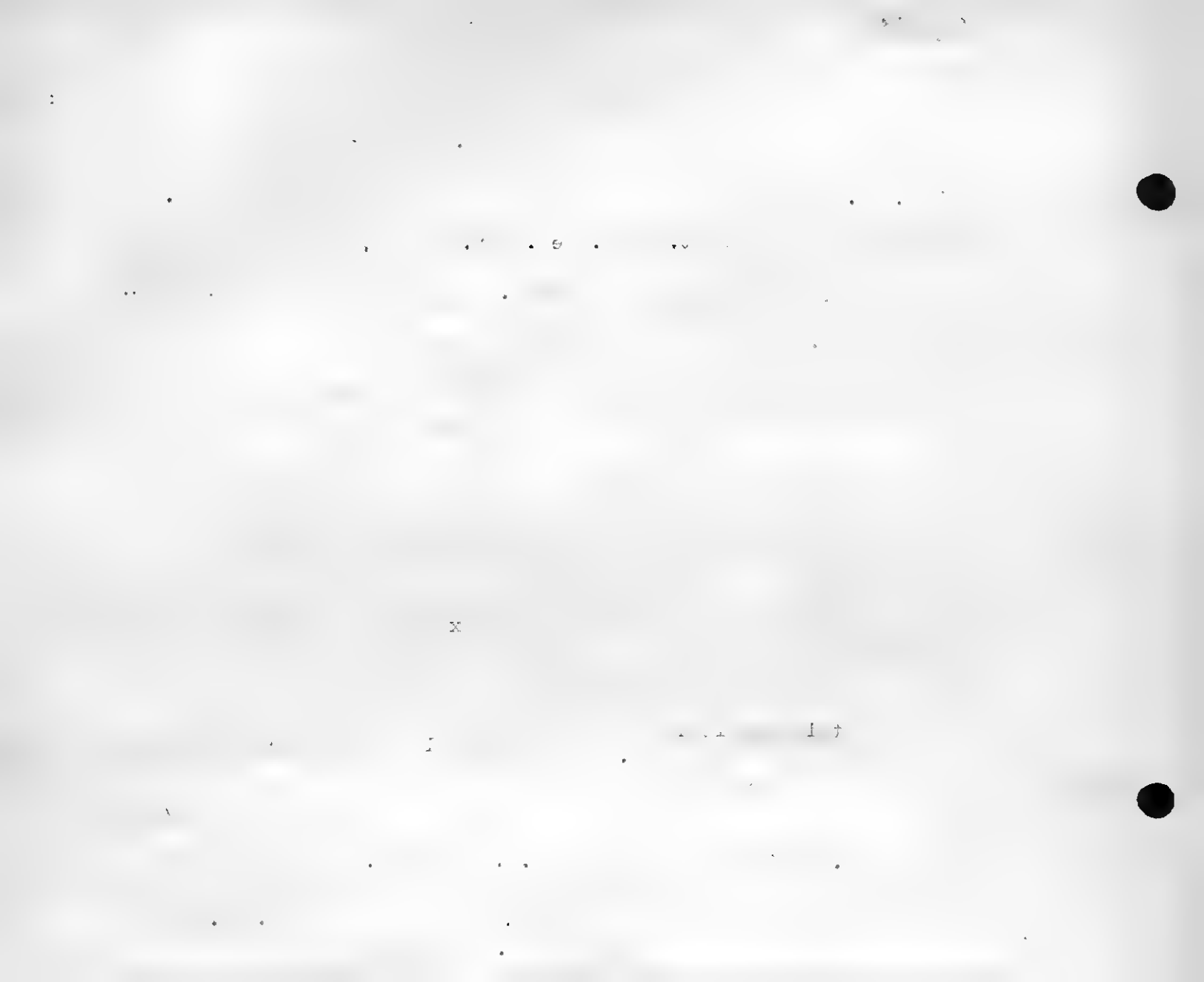
03581

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03575

1. DECEASED-NAME (Type or print) ELSIE		First		Middle		Last		2a. DATE OF DEATH 3 Month 23 Day 69 Year				2b. HOUR 2:30 AM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH Aug. 18, 1892				6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Co.				Md					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Great. Balt. Med. Cen.				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) None				12b. KIND OF BUSINESS OR INDUSTRY None					
13a. USAL RESIDENCE (Where deceased lived, if institution) STATE Md.		13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1424 Patapsco St.									
14. FATHER'S NAME Max B. Muller				15. MOTHER'S MAIDEN NAME Emma Hamel											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Family				Address Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) this hospital		21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that Dr. Rudiger Breitenacker attended the deceased from March 21, 1969 , to March 23, 1969 , that we last saw the deceased alive on March 23, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.															
22b. SIGNATURE Dr. Rudiger Breitenacker		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/23/69									
22d. PHYSICIAN'S NAME (Type) Dr. Rudiger BREITENECKER M.D.		22e. ADDRESS 6701 N. Charles 21204													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3 26 69		23c. NAME OF CEMETERY OR CREMATORY Western				23d. LOCATION (City or Town) Balto. Md.		(County) (State)					
24. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Thomas Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03582											
03576											
Item #6, Film 4410 3/24/69											
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR				
Florence Edwina Yewell					3 Month 18 Day 69 Year		3.30 am				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
female		white		11-5-1885		74 33 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		U.S.				Baltimore Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson, Md.			Dulaney Towson Nursing Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY, WHITE? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Balto. City			Balto.		YES		Statford Hotel street	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Francis E. Yewell				Florence ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				216-46-0683		T.K. Dankmeyer 929 N. Howard St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arteriosclerosis										3 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis										25 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Diabetes mellitus, mild.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 1958, to March 11, 1969, that (I) (we) last saw the deceased alive on March 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Harry B. Klinefelter										3/18/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
H. F. KLINEFELTER						550 N. BROADWAY					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		3-20-1969		Loudon Park Cemetery				Baltimore, Maryland			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson 1050 York Rd. 21204								MAR 20 1969		James J. J. J.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1/68

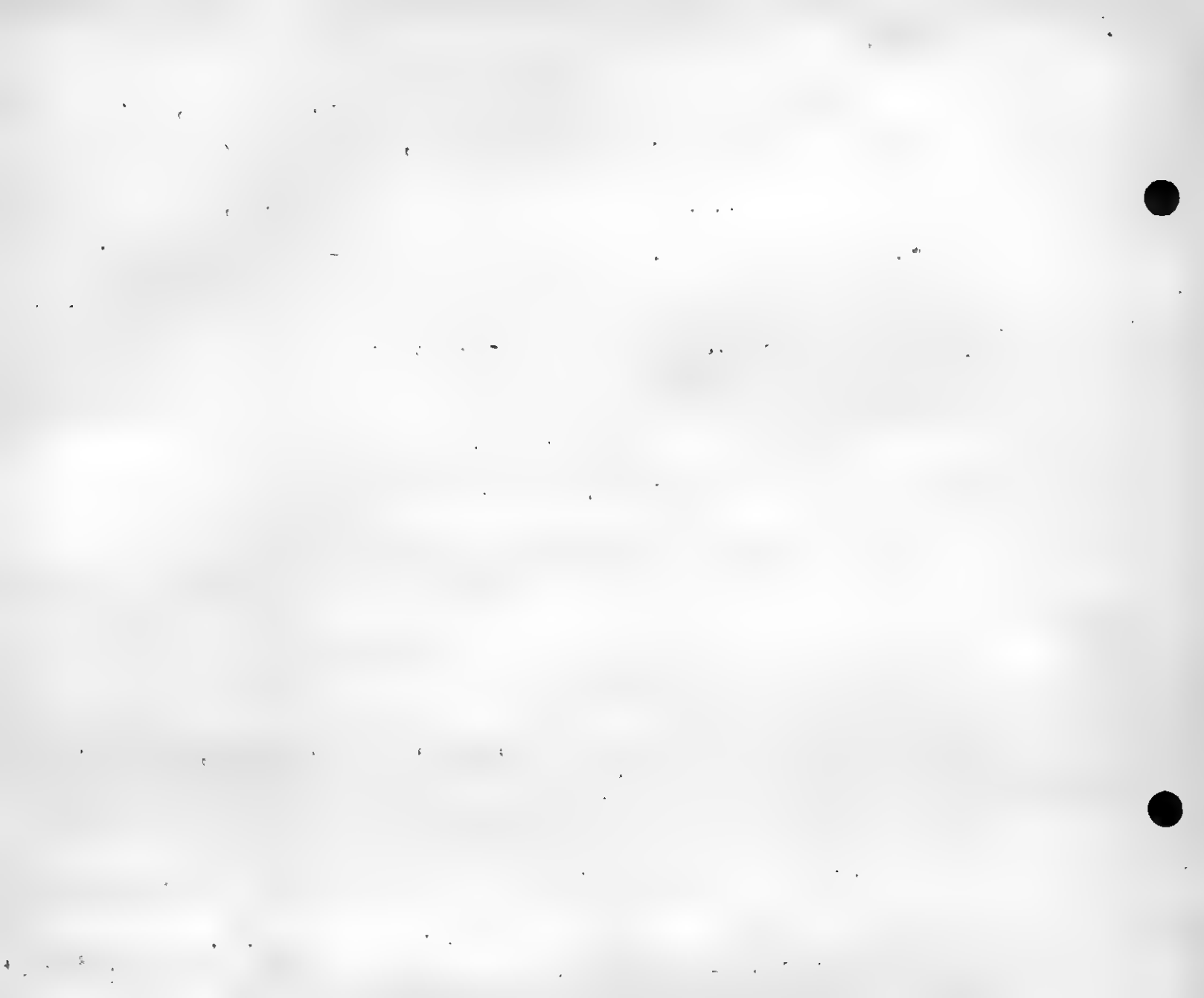
03583

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03577

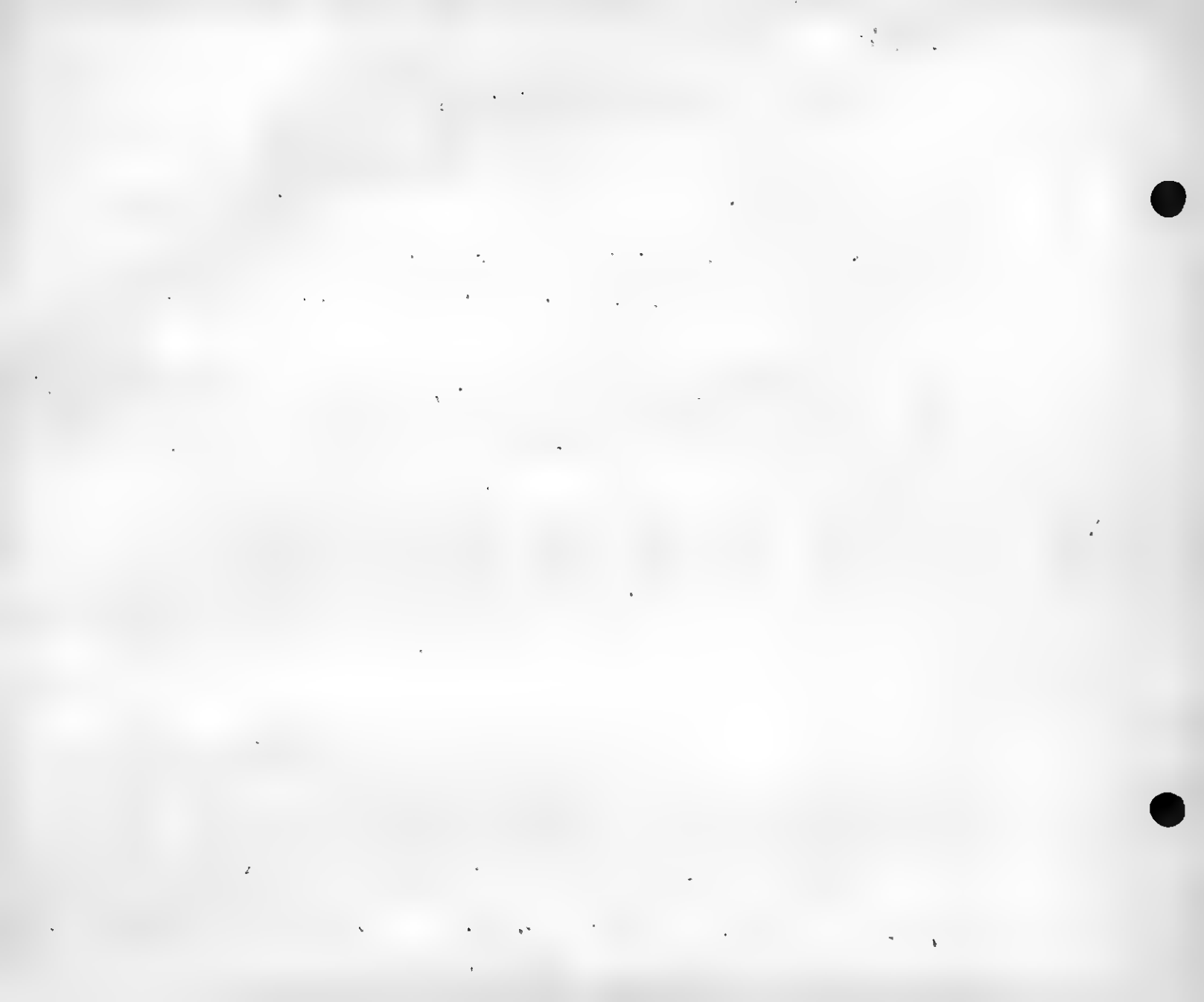
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
EDWARD		G.	MURRAY	MARCH	Month	31, Day	1969, Year	6:50 A.M.
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE	WHITE		JULY 10, 1911		YRS		MONTHS DAYS HOURS M.N.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE, Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		SELF-EMPLOYED		RESTAURANT		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2211 CHESTERFIELD AVE. #2121		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
DANIEL LEO MURRAY					ELIZABETH O'MALLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES		N.W. 2, 213-01-1363		MRS ELIZABETH MURRAY - SAME				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary infarction.								
4104								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) Pulmonary congestion.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from February 1, 1969, to March 31, 1969, that (I) (we) last saw the deceased alive on March 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)			22e ADDRESS		22d DATE SIGNED	
HUGH J. WIECH		HUGH J. WIECH			7620 York Road, Towson, Md. 21204		March 31, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/3/69		Cathedral Cemetery		Balto Md.		
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		DATE		
Mitchell-Wiedefeld Home		6500 York Rd. 21212		APR 7 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) HARVEY CLARENCE MYERS						2a. DATE OF DEATH Month 3 Day 25 Year 1969			2b. HOUR 7:55AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-27-1895		6. AGE (in years lost birthday) 74 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md					
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY WOOD		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.				13b. COUNTY CARROLL		13c. CITY OR TOWN BRIDGE UNION		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 204 E. EIDER ST.	
14. FATHER'S NAME First WILLIAM Middle MYERS Last MYERS				15. MOTHER'S MAIDEN NAME First ALBERTA Middle STUDOX Last STUDOX							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 218-14-1760		17. INFORMANT Address Records, Mount Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the lung metastasizing to Brain 162.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) chronic obstructive air way diseases.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-4- , 1969 , to 3-25 , 1969 , that (I) (we) last saw the deceased alive on 3-25 , 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W Newcomer						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/29/69		23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK				23d. LOCATION (City or Town) (County) (State) NEW WINDSOR RURAL MD			
24. FUNERAL DIRECTOR W. J. Zantler		ADDRESS BRIDGE		25a. REC'D BY REGISTRAR DATE MAR 27 1969		25b. REGISTRAR'S SIGNATURE W. J. Zantler					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

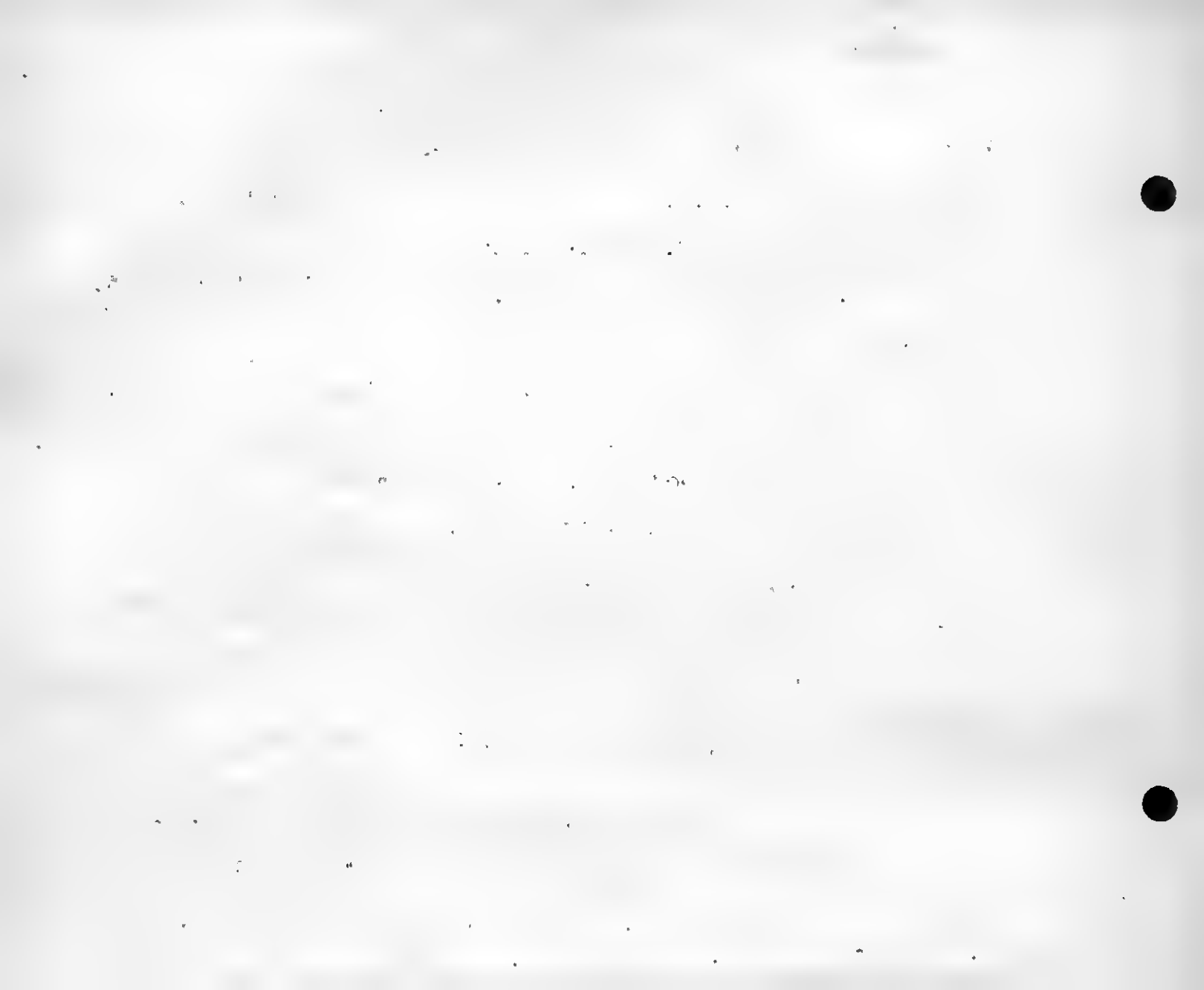
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

03585

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) KATIE			First	Middle	Last	2a. DATE OF DEATH 03 Month 06 Day 69 Year			2b. HOUR AM 12:10		
3. SEX FEMALE		4 RACE CAU		5. DATE OF BIRTH 1-22-88			6 AGE (In years last birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE CO. Md				
10 CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CENTR.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5921 Glenkirk Rd.			
14 FATHER'S NAME Michael Fisher			First	Middle	Last	15. MOTHER'S MAIDEN NAME Anna Fuchs			First	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT A. Trochenbrot			Address 5921 Glenkirk Rs.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4444 DUE TO, OR AS A CONSEQUENCE OF (b) POST OPERATIVE ATELECTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last? (c) PULMONARY EMBOLUS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES, ARTERIOSCLEROSIS											
19a. DATE OF OPERATION 3-02-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FEMORAL OCCLUSION			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from FEB. 24 , 19 69 , to MARCH 5 , 19 69 , that (I) (we) last saw the deceased alive on MARCH 5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard L. Smith, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED MARCH 6, 1969			
22d. PHYSICIAN'S NAME (Type) RICHARD L. SMITH M.D.						22e. ADDRESS 6701 NORTH CHARLES STREET					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3-10-69		23c NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery			23d LOCATION (City or Town) Baltimore Md.		(County)		(State)
24. FUNERAL DIRECTOR B. Dabrowski						ADDRESS 2818 E. Baltimore St.		25a. REC'D BY REGISTRAR MAR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



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03586

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03580

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) JOHN MACK NEELY			2a. DATE OF DEATH Month March Day 6 Year 1969		2b. HOUR 12 noon
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 3 1910		6. AGE (In years last birthday) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7 Ingleside	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD	13b. COUNTY BALTO	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7 Ingleside Ave.	
14. FATHER'S NAME First Middle Last DAVE NEELY			15. MOTHER'S MAIDEN NAME First Middle Last MARY Eady		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 214-14-6195		17. INFORMANT Mrs. J. M. Neely Address 7 Ingleside Ave. Caton, Md. 21034	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tumoral Coelentera - 10a1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Disseminated Melastosis DUE TO, OR AS A CONSEQUENCE OF (c) Sq. cell ca. Left Lung.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION Dec 27-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED metastasis 2nd lumbar vertebra		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 30 , 19 68 , to March 5 , 19 69 , that (I) (we) last saw the deceased alive on March 5 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alejandro Mejia MD		DEGREE MD		22c. DATE SIGNED March 11 1969	
22d. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD		22e. ADDRESS St Agnes Hospital - Caton Williams Hts			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-10-69	23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION (City or Town) (County) (State) ELlicott City Howard Md.	
24. FUNERAL DIRECTOR Higginbotham-Slack		ADDRESS ELlicott City, Md		25a. SIGNED BY REGISTRAR Charles J. Jones	
DATE MAR 11 1969		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
LAWRENCE LEE NEFF						March 7, 1969		3:30 PM	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		11 UNDER 1 YEAR	
Male		White		January 29, 1909		60 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Halethorpe		5605 Huntsmoor Road		Electrician					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Halethorpe				5605 Huntsmoor Road 21227	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Andrew J. Neff			Anna Fay						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
No			215-07-9536		Mrs. Catherine L. Neff, 5605 Huntsmoor Rd.				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <u>Bronchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF lost. (b) <u>Bronchogenic Carcinoma</u> (c)								5 Days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>69</u> , to <u>3-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Domingo C. Sorongon M.D.</u> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3/7/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. Domingo C. Sorongon</u>					22e. ADDRESS <u>3915 Hollins Ferry Road, Balto., Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		3-10-1969		New Cathedral Cemetery		Baltimore, Maryland			
24 FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Howard H. Hubbard, 4107 Wilkens Ave. 21229					MAR 12 1969		<u>Charles Judge</u>		

03588

CERTIFICATE OF DEATH

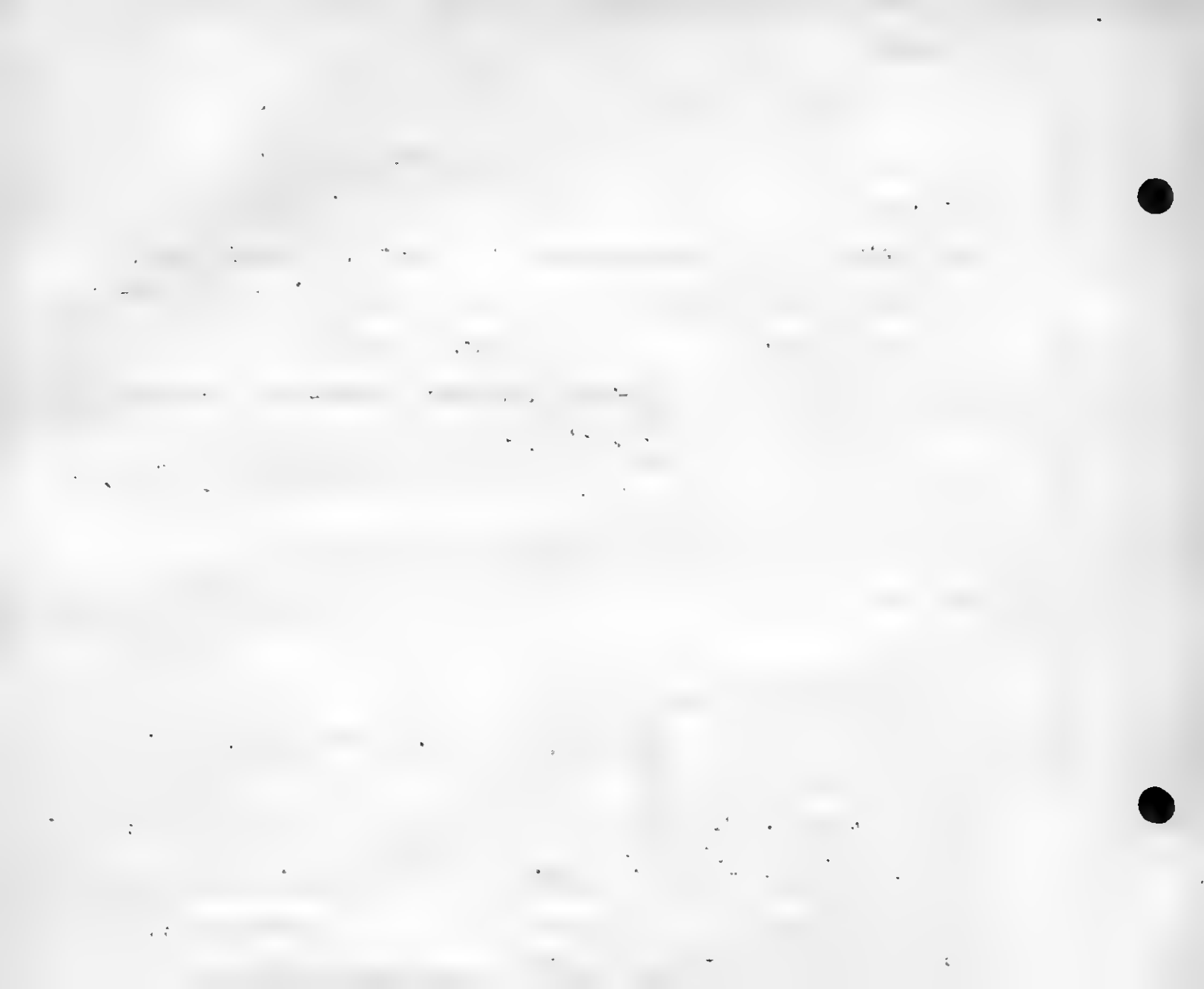
03582

1. DECEASED NAME (Type or print) JOSEPH JEROME NESER			2a. DATE OF DEATH Month March Day 12th Year 1969			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 18th, 1889		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10. CITY OR TOWN OF DEATH Towson, Balto Co.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cheasapeake Manor N.H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) (ret.) U.S. Industrial Chem.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 634 Register Ave-12	
14. FATHER'S NAME First Middle Last John H. Neser				15. MOTHER'S MAIDEN NAME First Middle Last Mary C. Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes WW-1			16b. SOCIAL SECURITY NO 218-03-0080		17. INFORMANT Address Mr. James M. Neser-634 Register Ave-12					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of 1519 DUE TO, OR AS A CONSEQUENCE OF Stomach & Duodenum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1969 DUE TO, OR AS A CONSEQUENCE OF (c) 1969										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11/11, 1968 to 3/12, 1969 , that (I) (we) last saw the deceased alive on 3/12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles F. O'Donnell				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/14/69				
22d. PHYSICIAN'S NAME (Type) Charles F. O'Donnell				22e. ADDRESS 1501 York Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/69		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md				
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-21212				25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE <i>Charles F. O'Donnell</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03589										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03583																													
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last julia P. NETRO										3 Month 18 Day 69 Year										12:00																													
3. SEX FEMALE										4. RACE White										5. DATE OF BIRTH Dec. 10, 1891										6. AGE (In years last birthday) 77 YRS.																			
7a. BIRTHPLACE (State or foreign country) Czechoslovakia										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Md.																			
10. CITY OR TOWN OF DEATH BALTIMORE										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Balto.										13c. CITY OR TOWN Lutherville										13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 119 Croftley									
14. FATHER'S NAME First Middle Last Andrew Pavelko										15. MOTHER'S MAIDEN NAME First Middle Last Julia (Unknown)																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b. SOCIAL SECURITY NO. 220-34-6145										17. INFORMANT Mrs. Julia Widra RD Hampstead, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> ACUTE MYOCARDIAL INFRACTION WITH HEART BLOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>8AM</u> <u>3/18</u> , 19 <u>69</u> , to <u>12:00N</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE <i>M. N. Al-Mumayez</i>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 3/18/69																													
22d. PHYSICIAN'S NAME (Type) M. N. AL-MUMAYEZ										22e. ADDRESS GR. BALTO. MED. CENTER																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE March 21, 1969										23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery										23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.																			
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.										25a. REC'D BY REGISTRAR DATE MAR 24 1969										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

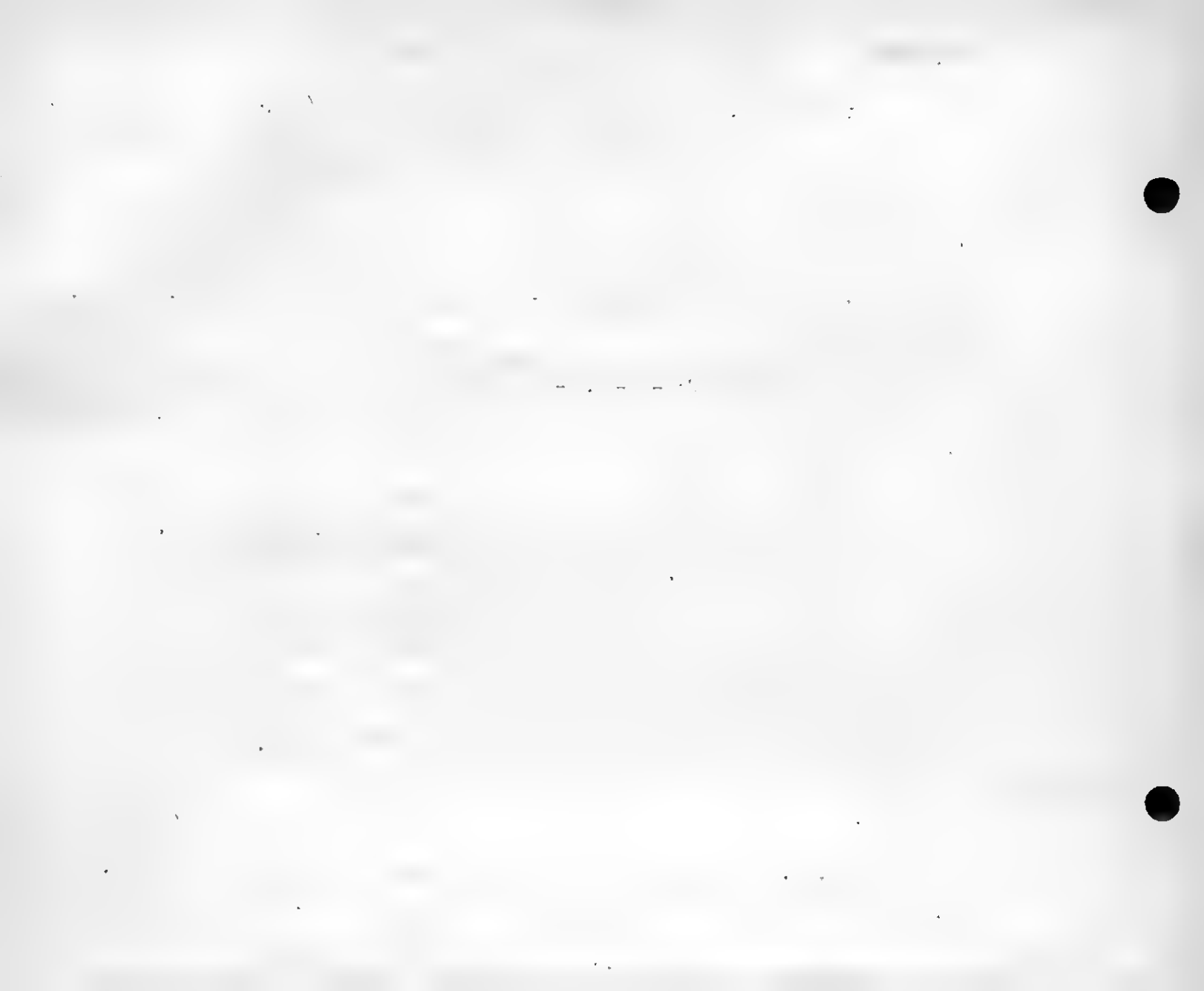
03590

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03584

1. DECEASED-NAME (Type or print) Margaret Nossel			First Middle Last			2a. DATE OF DEATH Month Day Year 3/26/69			2b. HOUR 9:10 AM					
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH 8/7/79			6. AGE (In years last birthday) 89 YRS. MONTHS DAYS					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2863 Chesterfield Ave.		
14. FATHER'S NAME Roger Ford			First Middle Last			15. MOTHER'S MAIDEN NAME Catherine Holian			First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 213-05-0146-D			17. INFORMANT Stella Maris Hospice Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infernal Obstruction 1538 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) PT refused surgery to relieve obstruction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 month				
										2 month				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from July 1st, 1969 , to Mar. 26, 1969 , that (I) (we) last saw the deceased alive on 3/23/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE David Nagel						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/26/69					
22d. PHYSICIAN'S NAME (Type) Dr. J. David Nagel						22e. ADDRESS 812 Mockingbird Lane, Towson, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3-28-69			23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem			23d. LOCATION (City or Town) (County) (State) Baltimore Md.					
24. FUNERAL DIRECTOR Foley-Corranagh J.H. - Catonsville, Md.						25a. REC'D BY REGISTRAR DATE MAR 28 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03591

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03585

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input type="checkbox"/> Month	Day	Year	2b. HOUR
FRANCIS L. O'LAUGHLIN					JR.	DATE ESTIMATED <input checked="" type="checkbox"/>					19	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR
male	white	6/29/49	19 YRS			March 15,					1969	2:00 A.M.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
MD			USA					Baltimore			MD	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Essex			Bowley's Qt. Road			ARMY						
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Baltimore		Essex				Rte 15, Box 690 Cgestnut Rd.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
FRANCIS L O'LAUGHLIN SR						BIGGS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS				
YES			ACTIVE		WM.C. CLUSTER							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries</u>												
8121 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				1:11PM 3/15 19 69				Subj. in auto- apparently racing another car				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) (Street)				21f. LOCATION Street or R.F.D. No City or Town County State				
				Bowley's Qt. Rd - Burke Rd.				Essex, Baltimore, Maryland				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				3/15/69		
						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			3/19/69		BALTO NATIONAL CEM.			BALTO. MD.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
J.G. CONNELLY SONS 300 MACE						MAR 19 1969		Werner U. Spitz				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5		1		03592		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03586			
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
LLEWELLYN		J.		O'NEILL				March 8, 1969		11 30 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		February 22, 1899		70 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Arbutus		908 Beechfield Avenue		Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore		Arbutus				908 Beechfield Avenue			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
William		O'Neill						Katherine French			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		21229			
No		218-36-9575		Mrs. Marie K. O'Neill, 908 Beechfield Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia left base</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>C.U.A. Right</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerosis - cerebral hemorrhage</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>67</u> , to <u>3/7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Cliff Ratliff, Jr.</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3/10/69</u>					
22d. PHYSICIAN'S NAME (Type)		Cliff Ratliff, Jr.		22e. ADDRESS 4605 Edmondson Ave., Baltimore							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		3-12-1969		New Cathedral Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE					
Howard H. Hubbard, 4107 Wilkens Ave.		21229		MAR 12 1969		<u>Howard H. Hubbard</u>					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03593

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03587

1. DECEASED NAME (Type or Print) JENNIE S. M. ORBAN				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month March Day 4 Year 1969		2b. HOUR 9:30 P.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MAR. 14, 1894	6. AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD Month MARCH Day 4 Year 1969	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 100 LOCUST DR.		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		2b. KIND OF BUSINESS OR INDUSTRY
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD		13b. COUNTY BALTO.	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 100 LOCUST DR.		
14. FATHER'S NAME First AUGUST Middle J Last PETERS			15. MOTHER'S MAIDEN NAME First ELLA Middle SCHOTTA Last SCHOTTA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 		17. INFORMANT ANTHONY P. ORBAN		ADDRESS 100 LOCUST DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF atherosclerotic cardiovascular disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 							
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) 			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No City or Town County State 			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE J. Nelson McKay		EXAMINER'S NAME (Type) J. Nelson McKay		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED March 4, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS		23d. LOCATION (City or Town) (County) (State) ELICOTT CITY MD.	
24. FUNERAL DIRECTOR E. S. MacNabb				ADDRESS 301 FREDERICK RD BALTO. 28 MD.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE J. Charles Jones	
				DATE MAR 7 1969			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 15 Filed 4/2/69 kkk

03594

03588

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last
Everett Rudolph Owens

2a. DATE OF DEATH Month Day Year
March 22 1969

2b. HOUR
11:45 A.M.

3. SEX
male

4. RACE
negro

5. DATE OF BIRTH
May 22, 1951

6. AGE (In years last birthday)
17 YRS.

IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (State or foreign country)
Bethesda Md.

7b. CITIZEN OF WHAT COUNTRY?
United States

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH
Baltimore County

10. CITY OR TOWN OF DEATH
Owings Mills

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
invalid

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. MD.

13b. COUNTY
Baltimore

13c. CITY OR TOWN
Owings Mills

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER
925 - 19th N.E.

14. FATHER'S NAME First Middle Last
Euell Howard Owens

15. MOTHER'S MAIDEN NAME First Middle Last
Mary Carletha Frazier

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give year or dates of service)
no

16b. SOCIAL SECURITY NO.
none

17. INFORMANT
mother

PO BOX 283 Address
Gaithersburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Respiratory Failure**
DUE TO, OR AS A CONSEQUENCE OF
(b) **Pneumonia**
DUE TO, OR AS A CONSEQUENCE OF
(c) **Spastic Quadriplegia**
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Spastic Quadriplegia 2° Cerebral dysgenesis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ Nat while ☐ at work ☐ at work

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that ~~the~~ (this hospital) attended the deceased from **Oct 8, 1956**, to **March 22, 1969**, that (I) (we) last saw the deceased alive on **March 22, 1969**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Alan S. Greenberg, M.D.

22c. DATE SIGNED
3-22-69

22d. PHYSICIAN'S NAME (Type)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

23b. DATE
3-26-69

23c. NAME OF CEMETERY OR CREMATORY
Arlington National

23d. LOCATION (City or Town) (County) (State)
Arlington VA.

24. FUNERAL DIRECTOR
George R. Snowden

25a. REC'D BY REGISTRAR
Mar 26 1969

25b. REGISTRAR'S SIGNATURE
John L. Judge

03595

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Maurice</i> First <i>R.</i> Middle <i>Owings Sr.</i> Last			2a. DATE OF DEATH <i>March</i> Month <i>15</i> , Day <i>69</i> Year			2b. HOUR <i>8:10</i> M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 16, 1912</i>		6. AGE (In years last birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md. USA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Pikesville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Quimper Court</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Supervisor Fisher, Mess, & Campbell</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Pikesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3 Quimper Court</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>F.</i> Last <i>Owings</i>			15. MOTHER'S MAIDEN NAME First <i>Bertha</i> Middle <i>Rawlings</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>212-09-4393</i>		17. INFORMANT Address <i>Mrs. Jessie S. Owings Pikesville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral metastasis</i> <i>1533</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic adenocarcinoma-especially liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Adenocarcinoma sigmoid colon</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 months</i> <i>5 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <i>7-15-64</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Car. Sigmoid colon</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-26-</i> , 19 <i>49</i> , to <i>3-15-</i> , 19 <i>69</i> , that (I) <i>(we)</i> saw the deceased alive on <i>March 10</i> 19 <i>69</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death.									
22b. SIGNATURE <i>Martin E. Strobel, M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-17-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i>				22e. ADDRESS <i>59 Hanover Rd. Reisterstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 18, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>			
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons</i>				ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

70280

